EXHIBIT C

FIRST JUDICIAL DISTRICT COURT

COUNTY OF SANTA FE

STATE OF NEW MEXICO

STATE OF NEW MEXICO, ex rel.,
HECTOR BALDERAS, Attorney General,

Plaintiff,

VS. NO. D-101-2017-02541

PURDUE PHARMA, L.P., et al.,

Defendants.

* * * * *

April 7, 2022

HIGHLY CONFIDENTIAL - SUBJECT TO FURTHER CONFIDENTIALITY REVIEW

Remote video deposition of JOHN E. SCHNEIDER, Ph.D., taken via Zoom teleconference, commencing at approximately 9:02 a.m. EST.

A P P E A R A N C E S

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LOIS ANNE ROBINSON, RPR, RDR, CRR, CRC

I N D E X

VIDEOGRAPHER:

Good morning. We are now on the record.

My name is Phillip Todd. I am a videographer for Golkow Litigation Services.

Today's date is April 7th, 2022, and the time is 9:02 a.m.

This remote video deposition is being held in the matter of the State of New Mexico, ex rel, Hector Balderas, Attorney General, versus Purdue Pharma, L.P., et al., for the First Judicial District Court, County of Santa Fe, State of New Mexico.

The deponent is Dr. John E. Schneider.

All parties to this deposition are appearing remotely and have agreed to the witness being sworn in remotely. Due to the nature of remote reporting, please pause briefly before speaking to ensure all parties are held -- are heard completely.

Counsel will be noted on the stenographic record.

The court reporter, Lois Robinson, will now swear in the witness.

JOHN E. SCHNEIDER, Ph.D.,

the witness, after having first been duly sworn to tell the truth, the whole truth, and nothing but the truth, was examined and testified as follows:

EXAMINATION

BY MR. MAJESTRO:

Q Good morning, Dr. Schneider. Again, I'm Anthony Majestro. I represent the state in this case.

Let me ask you, just to cover a couple of things, have you been deposed before?

A Yes, sir.

Q How many times, approximately?

A Maybe about 40 or so times.

Q Did you say four or 40?

A I'm sorry. 40. Four zero.

Q Okay. So you're a pro. You know -- you know the routine.

I will tell you that -- that -- that, generally, I'm -- I'm pretty laid back. If you -- if we need to take a break for any reason, let me know, and we can -- we can stop.

If I ask a question -- sometimes I ask questions that make absolutely no sense -- and

you don't understand the question, please ask me to clarify it in any manner. And we'll just go forward, and let's get through it.

I don't think we're gonna be here all day. But if -- if, you know --

I suspect we would take breaks every hour 15 minutes, hour and a half, generally my -- what I usually do.

Okay. First of all, what -- what documents do you have in front of you?

A All right. Well, I have my invoices --

Q Good. Okay.

A -- I have my report --

Q Uh-huh.

A -- unmarked, just a straight-up copy of my report, and I have your FedEx package unopened.

Q Okay.

A Oh, also a blank -- just a blank piece of paper for any notes that I need to jot down.

Q Perfect.

Can you go ahead and -- go ahead and open the FedEx package so we can save some time.

A Okay. I've got, looks like, Exhibits 2, 3, and 5.

Q Okay. And the other exhibits are the documents that were provided to me yesterday, and we'll just --

Which version of your report do you have in front of you?

A Well, what I have is the -- the original March 18th version. And then I just printed out pages, two -- two separate pages corresponding to the areas in which we made corrections.

Q Okay. Fair enough.

All right. Let's -- let me start with how you -- how you got involved in this case. When did you first become an expert in this case? And by "this case," I'm referring to the litigation initiated by my client, State of New Mexico.

A Yeah. I believe it was some -- probably sometime around October of 2021.

Q Okay. And prior to that time, had you been involved in the opioid litigation in any fashion?

A I was involved in one case or -- not one case -- one -- one matter where I was asked to opine on a -- on a market share in the Insys

case. Or I don't know. But it was the Ohio track, and it was -- I was testifying on behalf of Insys.

Q And was that the case brought by Cuyahoga County and Summit County, pending in the multidistrict litigation in Cleveland?

A Yes, that's correct.

Q And, so, the manufacturer, Insys, hired you?

A Correct.

Q And when would that have been when you were first hired by Insys?

A I -- I think maybe --

I honestly don't remember. I think probably -- probably three or four years ago, at least. Possibly more.

No. I think probably -- probably four years ago.

Q And I -- and did you do a report in that case?

A I believe so. I did a very brief report, yes.

Q Were you deposed in that case?

A Yes.

Q And I take it your work in that matter

ended with Insys's filing a bankruptcy?

A Yes.

Q Have you participated in the bankruptcy proceedings at all?

A No, I have not.

Q So let's move --

Between the time of Insys's bankruptcy and your work in -- on the New Mexico case on behalf of Kroger and Albertsons, have you done any work in the opioid litigation at all?

A No.

Q Was the -- this -- this New Mexico case the first time you were retained by Kroger or Albertsons?

A Yes, that's correct.

Q And -- and I -- and I -- I'm asking the question assuming that's who it is that retained you in this case.

A That's right.

Q Do you know how the -- how --

Well, first of all, who contacted you, first?

A Mr. Boone.

Q Do you know how Mr. Boone found you?

A I had worked with Mr. Boone once in the

past.
Q Okay. And what kind of case was that regarding?
A That was calculating the reasonable value in a personal injury case.
Q Okay.
A I'm sorry. The value -- I'm sorry. Reasonable value of medical bills.
Q Yes. Back in my other life, I knew how to do that stuff, before I became an opioid lawyer.
So did you -- had you done any work for Mr. Boone's firm other than this case or the one matter you just testified about?
A No, I haven't.
Q I'm -- so I have copied over into the marked exhibit folder all of the exhibits I'm going to use today, and some of them are the ones that Dr. Schneider has in front of him. The other of them are ones that were just given to us yesterday. And I'm gonna start with Exhibit 1, which is your invoices.
A Okay.
(DEPOSITION EXHIBIT NUMBER 1
WAS MARKED FOR IDENTIFICATION.)

MR. MAJESTRO:

Q So I presume that you have in -- you said you have your invoices in front of you. What -- what was provided to me were seven pages. Looks like they are printouts of spreadsheet columns, but, you know...

Is that -- is that what you have in front of you?

A Yes. That's correct. Seven pages.

Q And can you identify the seven pages for us, what those are?

A Yeah. I'll go in order. The first page is the -- is our --

When I say "our," I mean --

Q Well, I mean, let me -- that's probably a vague question. I meant generally, can you describe for the record what those pages represent?

A Yes. These pages are our invoices from Avalon Health Economics for this matter, for this New Mexico matter.

Q Are you working on other cases for Kroger and Albertsons or other cases in the opioid litigation?

A No.

Q Okay. So my crack legal assistant adds up that you have 885.92 hours through March 22nd, 2022. Trusting her math is correct, is there additional time that you have spent on this matter that is not reflected in these invoices?

A Just the time since the -- the date of the last invoice. So I would say since -- well, beginning on March 19th until present.

Q Would you identify for me --

So there's time on your invoices that is indicated as time you spent. I'm looking at the first page of Exhibit 1, the third line down, Dr. Schneider hours. I take it that's a reflection that is work that you did personally?

A Correct.

Q And, then, there are other indications on these invoices, staff research team hours. It has Kenna, Karen, and several other -- several other people. Can you tell me who those staff members are and describe for me their -- their background and experience?

A Sure.

Kenna is a master's in economics and is a health economist, or was a health economist. She's since moved on.

And Karen is a research analyst with us. Her background's in mechanical engineering and statistics.

Let me see who else is listed here.

Q Scheibling and Amy are the other two that I --

A Oh, okay. Yeah. Scheibling -- Scheibling --

Q Scheibling?

A -- Scheibling is an MBA background, and Amy is a bachelor's degree in, I think, biochemistry or something like that.

Q Okay. Are they all employees of Avalon Health Economics?

A Yes, that's correct.

Q What -- what is Avalon Health Economics?

A Avalon Health Economics is a healthcare economics and business consulting company, and we provide services to healthcare entities of various kinds. We do litigation support like we're talking about today is part of what we do, but we also provide services to medical device companies, diagnostic companies, med -- med tech companies, pharmaceutical companies, and usually

in the form of providing economic evidence of novel drugs and devices.

Q What do you mean by economic evidence?

A So cost-effectiveness analysis, cost-benefit analysis, that kind of thing.

Q Okay. Is Avalon Health Economics a for-profit entity?

A Yes.

Q Who -- who owns Avalon Health Economics?

A I'm one of the owners, Cara Scheibling is one of the owners, and then the third owner is Andrew Briggs.

Q All right. So we've marked Exhibit 1, the invoices as Exhibit 1. Did you prepare those invoices?

A No.

Q Can you confirm that they are, to the best of your knowledge, correct?

A Yes.

Q In the report, it appears that your hourly rate is $400 an hour, and you're -- you're billing staff at -- looks pretty uniformly at $250 an hour. Is that correct?

A That's correct.

Q All right. Is that your -- is that your current rate?
A Well, we -- we have different rates. This is -- my current rate ranges from 400 to 550.
Q How -- how do you decide what rate to charge?
A It -- it just depends on -- on the case and the expected volume of hours. So we applied a lower rate to this case because we expected a large volume of hours.
Q Do you have a different rate for trial versus -- and deposition testimony than the time you've billed on Exhibit 1?
A Yes.
Q And what are those rates?
A The normal deposition and testimony -- and court testimony rate's $1,000 an hour.
Q Is your work at Avalon your full-time job?
A Yes.
Q Do you have any other employment?
A Well, I have some outside appointments that are not a major source of income at all. For example, the San Diego State University, I

have an appointment there that doesn't run through Avalon, separate -- a separate engagement.

Q What percent of Avalon Health's work is litigation support?

A It usually hovers between -- I would say between 20 -- around 20 percent, maybe sometimes 25 percent, depending on the month.

Q Have you -- are you currently or have you in the past consulted with others in the pharmaceutical industry, other than this work you're doing for Kroger? By that I'm referring to drug manufacturers, those in the distribution chain, incl- -- up to and including pharmacies.

A Okay. So we haven't in the past worked for or consulted with pharmacies or distributors. We have and continue to work directly with pharmaceutical manufacturers in the capacity I described before conducting cost-effectiveness analysis.

Q Have you ever had occasion to do consulting work for pharmaceutical manufacturers involving opioid products or other -- or other pain relief products?

A Um, not opioid products. We worked

with a small biotech on a novel non-opioid pain relief product. I'm blanking on the name of the company right now.

Q Do you remember -- do you recall the name of the product?

A No, I don't.

Q Was it -- was it a medicine or device?

A It was a medicine.

Q Do you own any stock in any pharmaceutical, drug distribution, or pharmacy -- -ceutical -- pharmacy industry company?

A No, I don't.

Q Have you had any speaking -- speaking engagements on behalf of anyone in the pharmaceutical/pharmacy industry?

A Um, yes.

Q Tell me about that.

A Well, I've participated in some advisory boards, and -- but those are -- I mean, they're not really technically public speaking engagements, but they're speaking in front of a large group.

And I've also presented at conferences, and sometimes those presentations were linked to

a -- to some work we did for a pharmaceutical company.

Q Are those on your CV? We're gonna go over your CV in a little bit. So if they're on your CV, we'll deal with them then.

A Some of them might be. I don't remember offhand, but, yeah.

Q Okay. When we get there, we can add to that list.

All right. You said you had your CV in front of you? Do I remember that correctly?

A I -- I don't, but I can -- I can --

Yeah. I don't have it. Sorry.

Q Open Exhibit 3, the one that's...

(DEPOSITION EXHIBIT NUMBER 3
WAS MARKED FOR IDENTIFICATION.)

MR. MAJESTRO:

Q I think I need to have a discussion with my secretary about her -- her overly enthusiastic taping.

A Oh, I just have to take the bottom open. I'm fine.

Q Oh, that's smart. Last witness suffered through the tape.

A Okay. I have it.

Q Okay. Can you identify Exhibit 3?
A Yes. This is my CV.
Q And can you tell me when the CV was last updated, that version?
A Yeah. This one -- this one says updated November 11th, but I -- I believe this CV may have been --
Well, the CV's been updated since.
Q I have another -- I have another one that counsel provided for me yesterday that was too late -- we got it too late to put in your packet. On the electronic documents, it's marked as Exhibit 7.
(DEPOSITION EXHIBIT NUMBER 7
WAS MARKED FOR IDENTIFICATION.)
MR. MAJESTRO:
Q Do you have the link --
Is the link to the electronic documents in the chat? No.
MR. MAJESTRO:
Lois, can you -- can you put a link to the public marked exhibits in the chat?
THE COURT REPORTER:
I don't even have it. Nobody gave it to me.

MR. MAJESTRO:

Well, let's see.

All right. Let's try this.

All right. Somebody else besides me, if you can log in, see if you can pull that up, that link up.

VIDEOGRAPHER:

It's asking for a user name and password.

MR. MAJESTRO:

That's what I figured.

All right. Well, we'll do this another way.

A Mr. Majestro, I have the updated CV.

MR. MAJESTRO:

Q Oh, okay.

A If it -- yeah. If you want to just talk for --

Q Sure. That --

A I don't have it printed in front of me, but I have it. It was an attachment that I received yesterday.

Q I just did a share screen of what I received yesterday.

A Yeah. That's right. That's correct.

Q So we've marked this as, I guess, Exhibit 7.

Can you identify this document for us?

A That's my updated CV.

Q Can you identify what's changed since the prior version that was originally provided us?

A Sure. I think the main things were that -- changing the -- the header to say "updated April 2022," and then if you go to the section on peer-reviewed publications, which on the old version was page 4 -- should still be on page 4 -- those first three publications were added. They were recent publications, two of them very recent. One of them's late 2021.

And then I also, right above -- if you just travel up to the top of your screen there, that -- that Santiago case, I think, was added. Let me just confirm that.

Actually, looks like there might have been a few cases added at the bottom there.

Q And this is -- these are cases you testified as a witness --

A Correct.

Q -- in?

Okay. Well, let's turn to page 3 of the -- of the April 2022 CV, talk about your expert cases a little bit.

By my count -- I numbered them. So there are 22 cases? No. Actually, we're up to 26 cases?

A Right. Correct.

Q And it looks like the vast majority of the cases where you've provided testimony as an expert witness, you were testifying on behalf of the defendant in the litigation. Is that fair to say?

A Yes.

Q My count is three cases for the plaintiff, and the rest were for the defendant. I think that was on your original version.

A That sounds right.

Q It looks like all the new ones that you've added were cases for the defendant.

A Yes. That's correct.

Q So we've identified the Insys case. I just saw it on your list, and I lost it.

Okay. Here. Number 11.

A Yes.

Q Other than number 11 -- and if you want

to -- I'll ask you the question and give you a minute to review the list and -- and refresh your memory, if you need to.

Any of the -- does any of the other expert work involve the issues that you're testifying about in this case today?

A Just to clarify, when you say "involve the issues," do you mean involve the methodology or involve opioids specifically?

Q Well, let's -- I -- I take it the second -- the answer to the second question is no.

A Right.

Q That this is the only case -- this and the Insys case are the only case you've given testimony regarding opioids.

A That's correct.

Q Okay. So -- so let's -- so go ahead and answer the first question, if you can.

A Um, okay. So I think the -- in terms of the -- generally, the methodology, I would say it would be num- -- I'll just refer to the number in the case. So --

Q Sure.

A -- number 6. Number 6, UHS of Delaware

versus United Health Service, Incorporated. Number 15, Maryland Care versus Envolve, Incorporated. And that would be it from this list.

Q Okay. You say this -- you say "this list." Makes me wonder, is there another list?

A Well, there isn't, but this list is updated to drop off anything that's more than five years old.

Q Okay.

A So there are -- there were previous cases that I've worked on that would have involved a similar approach.

Q And the -- so I take it if I ask you about the cases that have dropped off -- we'll go through the same two questions -- the answer to the question that --

Well, let me just ask you. Were any of those cases that are not on this list that -- which you have previously provided expert testimony on involve opioids?

A No.

Q And were there -- there cases that, prior to five years ago that you provided testimony on, did any of those involve the same

methods that you're using in this case?
A Yes.
Q Can you identify those?
A One that comes to mind -- there might be others that I'm forgetting -- but one that comes to mind is work I did for the City of San Francisco on environmental impact of tobacco product waste. That involved testimony.
I did some other work for the City of San Francisco, similar type of work, similar methodology, and that -- but that didn't progress to anything involving litigation.
Q Environmental impact of tobacco waste? Is that like cigarette butts?
A Yes.
Q Okay. Let's talk about the two on the list you identified. Number 6, UHS versus Delaware, or UHS of Delaware versus United Health Services. What was involved in that case and what was your role in it?
A This was a -- well, like a -- a trademark infringement case. UHS of Delaware and UHS, Incorporated, of Harrisburg, Pennsylvania, both had the same, as you can see, the same acronym for their name. So it was a calculating

damages case associated with possible consumer confusion between the two brands, so attributing -- attributing costs from possible confusion, brand confusion to -- to damages.

Q So how was the methodology -- what methodology did you use in that case that was similar to the methodology you used in this case?

A Well, it was sort of a similar -- a simpler approach to attributing costs than apportioning costs. So there's -- it's identifying what the cost would have been or what -- what the -- let's say revenue or probably not cost -- but what the revenue would have been given no brand confusion versus possible brand confusion, the extent to which there could be brand -- the extent to which brand confusion could have affected revenue, that sort of thing.

Q Okay. All right. Then what about number 15, Maryland Care versus Evolve [sic]?

A Yes.

Q Envolve.

A Yeah. That case involved a health insurance provider. Maryland Care is a -- sort of an Affordable Care Act managed Medicaid program in Maryland, and they had retained --

brought in Envolve to manage a certain amount of their operations. The case -- Maryland Care alleged that Envolve had essentially mismanaged the -- or failed to do their duties in that engagement. And, so, I had to figure out how much of -- you know, it was a damages case, so it was figuring out how much of the sort of decrement in Maryland Care's patient level margins or enrolling level margins were attributable to Envolve's behavior and actions and things like that.

Q Okay. And, then, tell me about how the analysis in that case was similar to the analysis that you've done in this case.

A Well, in that case, there was the similar sort of problem where we have an external -- an exogenous influence of some kind, and the question is how much effect did that exogenous influence have on -- on the outcome of interest.

And, so, there was a -- essentially, an attribution process to try to figure out what -- what proportion of -- of -- of change, if you will, was attributable to Envolve versus attributable to other factors.

Q Okay. In any of the cases where you've served as an expert witness, have you ever been the subject of a Daubert challenge? And if you don't know what that is, I'll explain it.
A I've -- I've heard the term before. I don't believe I've ever been the subject of a Daubert challenge.
Q And by that, the subject -- someone's challenging your ability to offer the opinions that you were offering in that case.
A Right. No, I don't believe I've been the subject of a Daubert challenge.
Q To your knowledge, any of the -- have -- your prior expert work, did you do any of that work for any of the law firms that are involved in this case, other than the Insys case and, obviously, the Kroger and Albertsons case in New Mexico?
A I'm sorry. Can you just rephrase that? I'm not sure I follow.
Q I'm wondering if you -- if you have done any work for any of the other law firms that are involved in the opioid litigation other than the -- the two instances where you provided testimony.

A It's hard for me to answer that. We, over the years, worked for a lot of multi-state law firms. And I'm not also -- I'm not familiar with all the different law firms who are involved in the -- in this opioid matter.
Q In this case, have you had any -- been on any calls or meetings with lawyers who were representing other defendants?
A Lawyers who are representing other defendants.
Q Yes.
A Oh. Yes, I have.
Q Can you tell me about that?
A I mean, some of the calls that I've been on, there have been defendants from other pharmacies, other retail pharmacies, present on the call.
Q Is your report being offered on behalf of anybody other than Kroger and Albertsons?
A Not as far as I know.
Q Let's go back to Exhibit 1. Can you identify the billing entry that went with the calls you were on that involved defendants other -- the other pharmacy defendants?
A No. I'm not gonna be able to do that.

I don't recall which of these. I -- I do know the calls involving other defendants came much later in the process.

Q Were other experts on that call, those calls, or just other counsel?

A Just other counsel.

Q And what do you recall regarding what -- what the substance of -- of those calls involved?

A Well, they weren't materially different from calls preceding it in the sense that I was just -- we discussed the work that I was doing. I presented my sort of thoughts about my methodological approach in much the same way that I had been doing on other calls.

Q What else do you remember about those calls?

A That -- that's about it. They were otherwise unremarkable. Like I said, the --

Mostly, the attorneys for -- for other defendants were -- were fairly quiet in those calls, and I think they just wanted to get up to speed on what I was doing.

Q Did you take notes of those calls?

A Nothing -- no, nothing substantial.

Q Okay. Did you take insubstantial notes of those calls?
A I -- I'm sure I jotted some things down.
Q Do you -- would you have retained those notes?
A No.
Q So I -- Exhibit 7, I'm not sure -- yeah, Exhibit 7, updated list of cases where you provided testimony, were there other cases where you were retained as an expert and produced reports that you were not asked to give testimony?
A Yes.
Q Do you -- do you recall those cases and why you were not asked to give testimony?
A Well, they were primarily personal injury cases where I was asked to provide an opinion on reasonable value of medical bills. And in the vast majority of cases that didn't make this list, those cases were settled prior to the need to depose me, or prior to trial.
Q So let me ask you a little bit about those reasonable value cases. So we have a hypothetical case where a plaintiff is injured

and let's just say a -- a simple case, a car wreck, incurs medical bills, brings a lawsuit against the person he or she alleges is responsible for causing the accident and presents those medical bills as evidence of their claim for damages. What would your role be in a case like that?

A Yeah. In a case like that, I -- I would look at the medical bills and try to get an understanding of what happened, look at corresponding medical records, if necessary, again, to try to understand what happened, what services were provided, and then the goal becomes calculating the reasonable value of those services.

So it starts with the premise that the billed amounts are not the same as -- as the amounts that are transacted in the marketplace. So the -- the amounts -- in other words, the amounts on the bills are not reflective of reasonable value.

And in -- in most jurisdictions, reasonable value is something that's --

I'm not an attorney, so I don't remember the exact legal language around it, but

reasonable value is something that is either required or allowed to be put on the board. And, so, I would calculate what that reasonable value was. In other words, an approximation of what -- of what the services would be, what they would be transacted at in the marketplace.

Q So you would not be --

Let me strike that and ask it --

So, for example, in my hypothetical, the plaintiff in that case was somebody on -- that had Medicaid providing their health insurance, and -- and they go to the hospital. The hospital sends a bill for a hundred dollars, but Medicaid pays 50 -- 50 dollars. Would that be the situation where you would be called to testify about what that -- the value of those services actually was?

A Yes, something like that, although I wouldn't necessarily look at or concern myself with what a payor paid. I would approach it differently and not necessarily take that information into account. But, yes, otherwise, that's correct.

Q But how did -- how would you approach that?

A Well, there's a number of different ways to approach reasonable value. The -- in the case of professional services of medical bills, I typically look at benchmarking data sets, things like FAIR Health or Context 4 Healthcare, and use those data sets to determine median billed amount. And that's the -- so that's the billed amount.

So, you know, I know I just said that billed amounts weren't reflective of reasonable value. But things like professional services that occur at very high numbers, the billed amount is -- is appropriate if you look at the median where -- where you can tamp down the effect of extremely low est- -- or extremely low bills and extremely high bills. So that's -- that's for professional services.

For hospital services and ambulatory surgery centers, they use a different approach. Hospital services, I look at the Department of Health and Human Services cost reports, hospital cost reports, ATRs, and from those I'm able to take a medical bill and calculate, using the cost charge ratios from the hospital-specific hospital cost report, I'm able to calculate a -- an

estimate of the cost. And then I add on to that a rate of return, reasonable rate of return to develop a estimate of the reasonable value of the hospital service. Again, it's based primarily on the services provided as they're recorded in the bill.

Q Okay. Have you ever testified before Congress or -- or any state legislative body?

A Um, no. I -- I --

Well, I was deposed by a -- by the Department of Justice in a case that -- in a federal case involving physician-owned hospitals, and it was a long time ago. I don't know if that counts.

Q That was gonna be -- that was gonna be one of my next questions. But how about -- how about a criminal grand jury in either state or federal level?

A No.

Q Then the last area would be what I think your Department of Justice testimony is, statements or testimony given to a regulatory agency. So you identified the Department of Justice. And tell me about that instance again.

A Yeah. That was -- that was a case

where the -- there's some legislation enacted that limited the -- in some way limited physician-owned hospitals. So these were typically small hospitals where physicians had a majority ownership share. They had been -- they already were in existence. They had been permitted via some additional legislation added onto the -- what's it called? -- the anti-kickback kind of -- kind of legislation from many years prior. So there were legal entities, but then these additional restrictions were put on them. And in -- you know, the -- the physician-owned hospitals as a group sued or filed some sort of --

Yeah. Again, I'm not an attorney, so I don't remember the exact --

Q Sure.

A -- language around it. But they -- they -- they --

Q They challenged that rule somehow.

A Yes. Thank you. Yes. They challenged it, and they put me forward as their expert, one of their -- I was one of many experts, but I was an expert on the sort of functioning of physician-owned hospitals and, basically, the --

how -- what -- you know, whether they're sort of problematic in any way from a health services or health economics point of view and also whether they had a --

Actually, that had an attributable cost element to it as well in terms of trying to figure out whether the presence of physician-owned hospitals had any sort of deleterious impact on community hospitals, non-physician-owned hospitals.

Q All right. Let's go to the top of -- of your CV.

A Okay.

Q The education, B.A., University of Maine; M.A., University of Maine; Ph.D., U-Cal Berkeley. Any other education -- post-high school education that's not listed there?

A No.

Q The section on professional experience, is that complete? Is there anything missing? Any other professional positions you've had that are not listed there?

A Let me take a quick look.

Q Sure.

A No. I think that looks correct.

Q Your work at Oxford Outcomes, was that similar to the work you're now doing for Avalon?
A Yes, very similar.
Q Same question with respect to Health Economics Consultant Group.
A Yes, very similar.
Q What is the Gerson Lehrman Group Health Care Council?
A Well, this is a -- this is a group that -- GLG for short, and they -- it's an expert services group, not -- not just for litigation. In fact, mostly not for litigation. It's for people in the financial community who need a quick hourly consult. In this case, I am -- I'm part of their health care group. So, for example, a private equity investor would contact me through this group and say, you know, "Can you give me some sense of what's happening in the diagnostic market right now?" That kind of thing.
Q So your work -- your work for the Wall Street Journal, the weekly reviews you describe here, were they all published in the Journal? If I wanted to go back and pull those up, I could -- to -- to -- to the extent I have access to

Journal articles from 2005 to 2007, would I find them there?

A Well, in their professor journal section, yes, possibly. They were available. I'm not sure -- I haven't tried in a while.

Q Okay. But they were -- but they were publicly distributed through the Journal as opposed to a private subscription, some sort of other private subscription service?

A Well, I'm not sure about that. I think they -- they were -- this was for their thing or their product called The Professor Journal, and that was distributed to -- I think it may have been distributed on a -- on a -- on a membership basis or subscription basis like the regular Wall Street Journal. So I -- I -- I'm not sure that they were -- they weren't just necessarily posted for general consumption.

Q So it's not a product that was included with the Wall Street Journal. It's some -- it's some other product that they -- that they separately sold? Is that your understanding?

A Yes, that's correct.

Q In any of your professional consulting work, have you ever had to -- had occasion to

evaluate the cost benefits, economic cost benefits of prescription opioids for use in treatment of pain?

A No.

Q All right. Go to page 4 of the CV.

A Okay.

Q So page 4 starts a list of 54 peer-reviewed publications. Do you have other peer-reviewed publications that are not listed in this CV?

A No, not -- not -- there shouldn't be. I may have missed one or two along the way, but I don't think so. I think this is the full list.

Q In connection with your testimony today and your report in this case, do you rely on any of those peer-reviewed publications?

A I'm sorry. Just to clarify, do I rely on any of my own peer-reviewed publications?

Q Yes.

A I don't believe so.

Q Are any of them relevant to the testimony that you're going to offer in this case and that you've set forth in your report?

A Only to the extent that they -- that some of them involve methods that are -- that are

similar, not exactly the same but similar.

Q Can you give me a couple examples?

A Sure. We can go through.

Q Take a minute, if you want to look through the list.

A Yes. I will do that.

Well, do you want me to just flag them up as -- as we go or as I go through the list, or do you want me to just identify them and then we --

Q Why don't you identify them. And then if I have questions, I'll -- we can talk about specific ones.

A Okay. I'll go through the list, then, and I'll just jot down the numbers that I think are more or less relevant.

Okay.

Q Okay. So which ones?

A Okay. Do you want me to just rattle off the numbers?

Q Yeah. Well, just one at a time. If I have questions about --

A Okay.

Q We'll stop.

A Okay. Number 5.

Q Okay. What about that is relevant to the testimony -- that article, number 5, is relevant to the testimony in this case?
A Well, that's -- that's essentially an attributable cost exercise trying to figure out how much -- to what extent are genetic factors attributable to changes -- levels and changes in obesity.
Q Okay. What's the next one?
A Number 8.
Q Okay. Go ahead. Explain that one.
A Yeah. Number 8 is -- I mentioned before the tobacco product waste. This is one of those studies. This looks at -- this is testing an online simulation model to attribute costs of tobacco product waste to -- I think it was 30 large U.S. cities. And it uses a very simple simulation model -- a simulation model as a -- as a -- you know, as an exercise, a demonstration of how something like that could be done.
Q So how -- briefly, how did -- did you simulate -- how did you attribute the -- the cost of the waste?
A Well, it's -- in this --
Again, this was just sort of an

illustration in this paper. The idea is to look at the total litter costs --

And it was quite simple, actually.

So look at the total litter costs and apply a percentage of -- of all litter costs that are attributed or that might be attributable to tobacco product waste.

And, again, this is all literature-based.

And -- and, then, I think there's maybe a couple of other adjustments that are made, and then that's done -- you know, replicated for these cities based on the demographics of each of those cities.

Q And, so, this is -- this would be essentially the cost of picking up cigarette butts?

A Oh, it's -- we call it prevention and abatement. So, yes, it would be the cost -- the general cost of cleanup. So -- and some cleanup efforts don't target tobacco product waste specifically. They target instead general litter, so it's a matter of apportioning some part of the general litter to tobacco product waste.

Q And how is it that you figure out what portion is tobacco waste?
A Well, there's a number of different things. So there's some litter studies done at the -- at the city level from around the world. There was some --
I actually took part in one of the studies in San Francisco that did a litter -- on-the-ground litter survey as to determine what portion of the -- what direct proportion of the -- of the -- of litter found in the environment was attributable to tobacco product waste. So that's -- that's one -- well, that's the main source.
There are other estimates that are based more on the -- the smoking rates, number of people smoking, the amount of cigarettes smoked, and applying to that a littering rate. But that's -- that's not the approach I used in this paper.
Q In your work on tobacco product waste, did you, in allocating the -- the cost, did you allocate the cost based on which manufacturer -- which manufacturer's products might have led to the waste?

A I'm sorry. What do you mean, which manufacturer?
Q So I mean --
So you have a number of different companies who -- who manufacture cigarettes. Were you looking at their respective shares of the problem of tobacco waste at all?
A No.
Q Why not?
A I'm sorry. You said why not?
Q Yeah.
A Um, it just wasn't part of what I was trying to do. I was trying to focus more on the prevention and abatement cost total rather than any particular entity's responsibility.
Q Okay. What's the next one?
A I think it's number 18. That's -- yeah. Number 18, assessing the impact of state opt-out policy on access to and costs of surgeries and other procedures requiring anesthesia services.
Q What's an opt-out -- state opt-out policy?
A In this case, the opt-out policy was that states could opt out of limits that were put

on nurse anesthetists, practice limits or scope of practice limits I guess is what they're usually called. So if the state opted out of the limits on the scope of practice for nurse anesthetists, they -- they could then allow nurse anesthetists to do more, provide more anesthesia services mainly in outpatient surgeries but also some inpatient surgeries.

So the goal of this paper was to figure out how much -- whether there was any additional attributable cost associated with that, with being an opt-out state or being a not -- or not being an opt-out state just to see -- see what the effect of the opt-out states may have had.

Q And what methodology did you use in that case that's relevant to your testimony today?

A It -- it's -- methodologically, the approach is -- is -- is similar. I think the -- I can't remember what the data source was. I think it might have been --

I'd have to go back and check, but I think it was a claims data set, possibly Medicare data I believe we used for that. And the idea is to sort of figure -- use the Medicare data to

figure out the attributable costs to the opt-out policy. So it's looking at a -- how -- looking at changes over time in costs in the opt-out states versus the non-opt-out states.

Q What's the next one?

A The one below it, 19. This is actually very similar to the one above it. It's the same -- part of the same scope of research we were doing there.

Q Okay. What's the next one?

A Same. So same answers as above.

Q Okay.

A Not so much opt out. I think it was just unexpected. Disposition means outcomes that were not expected.

Q Okay. What's the next one?

A Twenty-seven.

Q That's another tobacco litter case?

A Yeah. And this one in tobacco control was a summary, kind of a brief summary of the work I'd done in San Francisco. The work in San Francisco was never published as such. It was a report, a technical report provided to the city, to the --

Q Hold on one second, guys. I'm gonna

see if I can get the dog...

(Pause in proceedings)

MR. MAJESTRO:

Q All right. I'm back. I'm sorry.

Did you -- why don't you repeat that answer, because I don't know if we got it on the record. I certainly didn't hear it.

A Okay. I'm sorry. You're gonna have to repeat the question, because I want to make sure I answer the right question.

Q I think the question was --

Well, it's the same question we've been going on. It's how is this paper relevant to the opinions you have today? You were telling me that this was -- you were describing the San Francisco -- your San Francisco work.

A Right. I think I finished my answer. So I -- I -- I was, as I said before, I was engaged by the City of San Francisco. It's quite awhile ago, actually, several years preceding even this -- this paper. This is 2011, Tobacco Control. So this paper summarizes that work in a very general, sort of conceptual way.

Q Okay. Are there any others?

A Twenty-nine. So 29 I provided a

reference to before in the context of that DOJ case.

Q Right.

A Item 29 reflects the work I did on phys- -- some of the work I did on physician-owned hospitals. And in this case it's attributing costs of physician-owned hospitals to overall Medicare expenditures at an area level.

Q Okay. Next one?

A Oh, let's see. That was 29. So looks like 37.

Q Okay.

A I marked 37 just because it had to do with specialty hospitals, and I had done a lot of work in that area. I don't recall exactly what the scope of this particular paper was. I think it was an overview of the issues, so more of a conceptual paper.

Q Okay. Next one?

A Forty. Okay. Yeah. So, again, specialty hospitals. This is the impact, similar to the paper up above, which was the impact on Medicare expenditures. This is the impact on -- on general hospital managed performance. So it's attributing some proportion of the impact of

specialty hospitals on general hospital management departments.

Q Okay. Next one?

A Forty-five. I flagged this one up because it had a lot to do with clinical practice guidelines, and that's something that I -- I reference in a couple of different places in -- in my -- in the current -- in the report for today's matter. This represented some work I did on the impact of clinical practice guidelines, private-paying organizations, things like that.

Q Okay. The next one?

A The last one would be -- I marked 51. And this was the -- this was looking at the -- the effect on hospital operating costs of -- of changes in mandatory rate regulation. So, again, this is an attribution kind of process using a regression analysis over a period of time.

That was the last one.

Q Okay. Sure.

And, then, turning to your technical project reports and manuscripts.

A Actually, before we start that, could we take a quick break?

Q Sure.

A Great. Thank you.
Q I tell you what. Let's take five or -- five -- five or ten minutes or so, and then, Doctor, what I would like you to do before we get back on the record is go through these 19 and pick out the ones we -- we should talk -- same question as I asked you with respect to your peer-reviewed publications; which, if any, of these would relate to methods or work that would be relevant to your testimony that you're giving in this case.
A Okay. Well, then, I would -- I would like -- ten minutes would be good?
MR. MAJESTRO:
Sure.
MR. BOONE:
Fifteen minutes?
MR. MAJESTRO:
Q We'll just take 15 minutes. We'll come back at 10:30.
A 10:30. Okay.
VIDEOGRAPHER:
The time is now --
Are we ready to go off the record?
MR. MAJESTRO:

Yes.
VIDEOGRAPHER:
10:15 a.m., we're off the record.
(OFF THE RECORD.)
VIDEOGRAPHER:
10:30 a.m. We're back on the record.
MR. MAJESTRO:
Q All right. Doctor, I think when we took a break I had asked you to go through the section of your report dealing with technical projects and manuscripts, or technical project reports and manuscripts, and asked you to identify -- the same that we did for your peer-reviewed publications and identify ones that might use methods or otherwise be relevant to your opinions in this case. Did you have a chance to do that?
A Yes, I have.
Q Okay. So are there any?
A Yes, there were. I identified six different technical reports.
Q Okay. And which ones? Go ahead. Which ones -- let's start with the first one of those.
A The first of those is number 5.

Q Okay. Can you explain how -- how that would meet the criteria that I've -- I've asked you to use?

A Yeah. So this is relevant because it looked at a -- the focus was alcohol-attributable costs to the City of San Francisco, and, of course, there was an additional -- as that title implies, there was an additional element, too, which was developing a regulatory fee structure to -- to abate those costs.

Q Which number is that?

A Oh. I'm sorry. Well, it's -- it's -- I'm sorry. It's number 5 on the old --

So what I did, another -- I forgot I made another edit to this manuscript. I mean to this CV.

The first four elements on the -- on the old CV were -- I noticed were marked as in review. Those were manuscripts that were in review.

Q Uh-huh.

A And those had all either been published in some form or another or -- or not. So I -- I deleted all of those because none of those were relevant anymore.

Q Okay.
A That was an edit I made for this updated April one. So -- so we're actually talking about number 1. I'm sorry. I'm going to have to amend my numbering as we go --
Q Okay.
A -- but I can do that on the fly.
Yes. So did you have further question about that?
Q Yeah. Now that I -- why don't you explain again why that one meets the criteria? Because I was scratching my head when I was looking at what's at number 6.
A Yeah, yeah. Apologies again for that. That's -- I confused myself on that.
So, yeah. So item number 1 on the technical report, entitled "Regulatory Fee Structure Analysis For Alcohol-Attributable Costs in San Francisco." So this case -- or not case. It's not a litigation matter. But this endeavor was to calculate, number 1, the costs -- the alcohol-attributable costs to the City of San Francisco --
So this would be abatement costs, using the language of our -- our current matter.

-- and, then, on top of that, creating a regulatory fee structure. So it -- a means by which alcohol manufacturers or distributors could -- could potentially pay for that attributable cost.

Q How could I get a copy of that paper?

A Yeah. That's a good question. I -- I think it's available through the -- through the city, but I'm not a hundred percent sure. I -- I can -- I can get back to you on -- on where that might be available.

Q Do you have a copy -- do you retain a copy of it?

A I might. It was a long time ago, so -- 12 years ago or so. So I -- I'm not sure how readily I could put my hands on it.

Q Okay. Appreciate it if you would make an inquiry on that and report back to Mr. Boone about that.

So how did you determine what the alcohol-attributable costs were for San Francisco?

A Um, well, what we did in that case was looked at the -- the effect of alcohol-related --

So, essentially, again --

This is 12 years ago, so my memory's a bit fuzzy, but I can give you the broad strokes.

Looking at the -- first of all, identifying alcohol-attributable conditions and illnesses and things like that, so fatty liver disease, alcohol-related fatty -- fatty liver disease, things like that, other types of acute alcohol poisoning-type issues, things like that. And it's figuring out what the costs of those were to the city.

So, obviously, all the -- all of the -- all of those types of -- of conditions don't fall on the city because some of them are covered by private insurers.

Q Dr. Schneider, I hate to interrupt you. I've got somebody at my front door, and I'm the only one home. And, so, let me go -- let me real quick deal with that. We can stay on the record. I think this will just take a minute. Probably just somebody who needs me to sign for a package.

A Okay.

(Pause in proceedings)

MR. MAJESTRO:

Q Apologize for that. I'm back.

So we're still on the record? Okay.

So, Dr. Schneider, you were explaining how -- how you determined what the alcohol-attributable costs were.

A Right.

Q Did you complete that answer?

A Well, I'm not sure where I left off, so I'll just repeat it.

So the -- the agreement was to figure out first how to -- oh, I'm sorry -- first, to identify types of conditions, both chronic and acute, that are associated with alcohol use and then to take those identified conditions and then to use data from the city, claims, you know, from their hospitals, that kind of thing, or discharge data from their hospitals, claims data from their clinics and things like that to identify what proportion of -- of services, alcohol-attributable condition services, was the city paying for and had the city paid for over some period of time. I don't remember the time frame. That was essentially it.

And then the next -- the second half of that was to figure out, okay, well, if the cost is X, how could we potentially go to the manufacturers and -- and distributors and -- and

seek abatement for those costs?
Q So the cost you looked at, did you look at the, for the diagnoses and the treatments, did you look at what the city was expending or just the costs in totality?
A Well, I think the -- I think the research included some element of both. But mainly, the city was interested -- and the city was the -- was the client in this case. They were interested in what they were paying for alcohol-attributable illnesses and conditions.
Q Did you look at the consequences beyond the physical impact of alcohol on a particular person, consequences to third parties or the city in general that could --
A Could you give me a for example?
Q Babies born who've had neonatal alcohol exposure, whether or not they had increased costs for schooling, for example.
A Yeah, okay. I -- I don't recall whether that was part of the scope or not.
Q Did you look, like, things like law enforcement expenses that were related to alcohol use?
A No. That -- that -- I'm quite sure

that wasn't part of the scope. I think the scope was healthcare-related costs.

Q All right. Next technical project report and manuscript?

A That would be the one -- the one below it, number 2, item number 2. And this one was actually very similar in every respect to the preceding one, the alcohol-attributable costs. This was -- although it's a different title, it was essentially the exact same analysis for calorically sweetened beverages.

Q Okay. Next one?

And same -- same question I'd have on that one. If you can retrieve a copy of that, would you please let Mr. Boone know?

A Yes, I will.

Okay. The next one, I have to do the renumbering in my head. That would be number 6.

Q Okay.

A This was a analysis of California's single-parent healthcare proposal at the time called SBA40 and for the California Association of Healthcare Underwriters. My agreement here, our agreement here was to figure out the -- what the cost impact would be of the single-parent

healthcare proposal on California -- on the California health system. So it involved a lot of different cost attributions, sort of mechanisms and analyses.

Q Okay. Next one?

A So this would be the --

Number 9 is the -- the relationship between organizational performance and health status in the VA. This -- this didn't involve -- that particular project didn't involve costs, but it was, instead, trying to attribute clinical practice guideline efforts or adherence to clinical practice guidelines as the outcome measured for organizational performance and attribute those to health status measures in the VA system using VA claims data.

Q Okay. Next one?

A The work described in number -- in item number 10, which is generally -- that -- actually, there's one or two things listed there. Actually, item number 10 and 11 are kind of related. But 10 is more specific to what we're talking about today, and that's looking at the cost impact, the attributable cost of specific managed care regulations in California in 1999.

Q Okay. Next one?
A I think that's -- I think that's it. Did we go through six or did I miss one?
Q I think we've gone through six.
A Yeah. Because I identified six. I just lost track, with the interruption, of where we were at.
But I don't think -- in any case, there are none below that last one I just mentioned.
Q Okay. All right. Did you prepare your CV?
A Yes.
Q Do you use a different CV for non-testifying work?
A No. I just have the one CV.
Q What professional organizations are you a member of?
A Um, it's changed periodically over the years, but I think right now it's just the International Society of Pharmacoeconomics and Outcomes Research, or ISPOR, and the Academy of Managed Care Pharmacy.
Q Okay. Have there been other professional organizations you've been a member of in the past?

A Yeah. I've been sort of in and out of the International Health Economics Association, the American Economics Association --

Well, maybe -- maybe just those two.

Q Did you have leadership roles in any of the -- the professional organizations you've identified?

A No.

Q When you were first retained by Mr. Boone, what were you asked to do?

A I was asked to -- to analyze the attributable costs of opioid use disorder in the state of New Mexico and -- and use that to determine abatement costs or an abatement cost ceiling.

Q Explain what you mean by an abatement cost ceiling.

A Well, the ceiling that -- the ceiling word was -- was my word, not Mr. Boone's. My approach to -- to this was to --

Essentially, we have a large number of studies that have been done on this topic. I was aware that -- that -- that the plaintiffs were also engaging -- at the time I was engaged, I -- that the plaintiffs were also engaging in their

own assessment of abatement costs. So what -- what I viewed my job as is to come up with an alternative method of calculating an abatement cost ceiling.

And, again, just to clarify, what I mean by abatement cost is simply what -- what the actual attributable costs of, in this case, opioid use disorder, or OUD, would be in the state of New Mexico, based on my opinion, based on my approach to this problem.

Q In your work in the multidistrict litigation proceeding in Cleveland, did you have occasion to look at the reports of other experts who were doing this kind of work?

A No.

Q Prior to --

Well, I assume you've reviewed the reports prepared by Dr. Miller and Dr. Dobson that plaintiffs have retained in this case; correct?

A That's correct. Yes.

Q Prior to reviewing those reports, have you had occasion to look at the work of any other expert that was attempting to calculate abatement costs or similar damage -- damage analysis?

A I -- I -- I did look at a couple of other reports.
Q And what were -- what would those reports have been?
A I think I looked at a report by Jonathan Gruber. And there was another one. I can't remember the -- the author's name. I think I looked at -- yeah, Gruber and another report from -- from -- which I don't think were -- had anything to do with New Mexico. They were from a prior -- you know, prior track.
Q Do you -- do you know which case those came from?
A No, I don't.
Q I didn't note in your report that -- that you had looked at either one of those, those documents. Do you still have those reports?
A Yes. I believe so, yeah.
Q At some point I'd ask you to identify those reports to -- to Mr. -- Mr. Boone.
A Okay.
Q Were you given any assumptions in this case?
A Please describe more what you mean by that.

Q Sometimes in a case the party will tell the expert "I want you to assume X is true and then do analysis based on that assumption." Were you given any assumptions from counsel or from your client, Kroger and Albertson [sic]?
A No, I wasn't.
Q All right. Let's -- I'm gonna talk about the information you reviewed in this case. Do you have somewhere a list of documents that you reviewed or relied on?
A No. I didn't -- I didn't list them out in the report in one place. They're just cited throughout.
Q Did you review, other than the expert -- two expert reports we've talked about, Gruber and the one whose name you can't remember, did you review any documents in connection with your opinions in this case that are not identified in your report?
A Um, I would say there were probably some peer-reviewed literature that has been retrieved over the time period I've been working on this, and not all of which is -- is cited here.
So, in other words, I -- I retrieved

probably more than I needed, and some of it ended up not getting cited. So in that sense, yes, there were some other materials reviewed.

Q And by "retrieved," do you have a file in this case where -- that would contain that -- those additional articles that you retrieved but did not cite in your report?

A Well, I'm not sure if I have the full text of the articles I didn't retrieve -- I'm sorry -- that I didn't cite. I might have some of them. So, yes is -- partially, yes, I will have some of them.

Q Okay. And that -- I'd appreciate if you would -- you would give those documents in that list to Mr. Boone also.

A Okay.

Q Did you review any testimony?

A No.

Q Did you review reports from experts that were attained by -- were retained by Kroger's and Albertson [sic] or any of the other defendants?

A Yes, I did review some of those reports.

Q Okay. And which one? Can you identify

those for me?
A Well, I reviewed the report by Dr. Dobson, the report by Dr. Miller, the report by Dr. Kessler, and the report by Mr. Girardi.
Q In your report you identify -- in the revised report you identify LoSasso?
A Oh, yes. I'm sorry. I left that one out. Yes. That is a very recent addition. I reviewed the report by Dr. LoSasso.
Q And Dr. Glickman?
A Yes. I was -- I was -- I only reviewed one page from or a couple pages from Dr. Glickman.
Q Okay. What in his report did you -- did you review?
A In Dr. Glickman's report?
Q Yes.
A In -- it was the -- his table identifying market shares for Albertsons.
Q Okay. And what did you review with respect to Dr. LoSasso?
A Same. A table regarding market shares but for Kroger.
Q Did you review any of the documents that Kroger or Albertsons produced in this case,

internal company documents?
A No, I don't believe so.
Q Did you conduct any independent or outside research, apart from the data that was provided to you?
A Well, explain that a little bit better.
Q I intend that question to be broad. I mean, that is, I take it that --
Well, the -- the literature that's cited in your report, that's literature you developed. By "developed," I meant you went out and got as opposed to literature that was provided to you. Is that correct?
A That's right. Yes.
Q So -- so other than the literature that's cited in your report, did you -- did you conduct any other independent or outside research?
A No. I think the report reflects the work that I did.
Q You testified briefly about conference calls with counsel for some of the other pharmacy defendants in this case. Have you discussed your testimony or your opinions with anyone else other than what you've described previously? And --

and your clients in this case.
A No.
Q What documents did you review in preparation for your testimony today?
A I reviewed the -- sort of the major sources that I relied on in terms of the published literature, the Society of Actuaries report. My own report was reviewed again, and some of the plaintiff expert reports, so Dobson, Miller, and Girardi. I think that's pretty much it.
(DEPOSITION EXHIBIT NUMBER 2
WAS MARKED FOR IDENTIFICATION.)
MR. MAJESTRO:
Q Okay. So we've marked as Exhibit 2 your report dated March 18, 2022, which I believe you have in front of you.
A Yes.
(DEPOSITION EXHIBIT NUMBER 6
WAS MARKED FOR IDENTIFICATION.)
MR. MAJESTRO:
Q And, then, we've marked as Exhibit 6 the revised report, which is dated March 8 -- well, it's revised April 5, 2022. And I believe you testified that you have printed out the

pages, the particular pages that changed in -- from March to April.

A Correct.

Q So the -- does the revised report dated April 5, 2022, contain all of your opinions that you intend to offer in this case?

A Yes, with the caveat that if anything new comes along that I'm asked to opine on, I would amend my report.

Q Okay. And you would expect that that amended report would be provided to us prior to trial?

A Yes, I would expect that.

Q Have you created any demonstrative exhibits for use at trial, other than the -- what's contained in your report?

A No, I haven't.

Q Do you have a plan to use demonstrative exhibits at trial?

MR. BOONE:

Object to the form.

A I -- I have not given that any thought yet.

MR. MAJESTRO:

Q Do you plan to testify at the trial of

this case?

A If asked to, I will, yes.

Q Do you know when the trial is?

A Um, not off the top of my head.

Q Have you been given the trial date, I guess is the question.

A I -- I don't recall whether I have or not.

Q Okay. What are the pages that are new in the April version of the report that you have printed out?

A Page 34, table 7-1 includes an edit. And, then, the other is the -- would be the -- essentially, new page 41, which includes the addition of a section 8.51 and 8.52 and table 8-2.

Q Okay. Why were those added in April?

A As I was reviewing my report in preparation for this deposition, I noticed a -- a typo on table 7-1. So that's the reason behind the 7-1 edit. That's a typo that was inconsequential to the analysis. It was not a -- an error, didn't reflect an error in my calculations. It just reflected simply a typo on the table and copying and pasting of the wrong

numbers into the table.

And, then, the reason for adding section 8.51 and 8.52 was that I had been made aware of Dr. LoSasso's report and Dr. Glickman's reports, and I did not have those at the time of the March 18th submission of this report. Having had those, I thought it would be useful to -- to continue my -- continue section 8.5 and show how those market shares would relate to -- to actual retail pharmacies. So I essentially had this as an example.

Q When did you receive those reports?

A I -- I don't recall the exact day, but it was just a few days ago.

Q And were those reports dated March 18 also, or thereabouts?

A I believe so, yes.

Q Was there any reason --

Did you request those reports or did counsel just give them to you?

A Counsel gave them to me.

THE COURT REPORTER:

I didn't hear an answer. Was there an answer?

MR. MAJESTRO:

Yes. He said counsel gave them -- gave them to him.

THE COURT REPORTER:

Thank you.

MR. MAJESTRO:

Q All right. Dr. Schneider, I'd like to go through your opinions in this case one at a time. So what is the first opinion that you intend -- that's contained in your report that you intend to offer testimony regarding at trial?

A Well, my report develops a number of opinions, I think probably maybe five or -- five or six opinions. So my very first opinion would be that causation of the opioid problem or opioid utilization and opioid use disorder is multifactorial and attributable to several different causes, primary causes, and secondary factors.

Q Okay. So why did you -- can you identify for me the -- what your opinion is regarding what are the causes of the -- of opioid use disorder in New Mexico?

A Sure. I would --

Q Can we direct -- can you direct me to a particular page in your report that would be

helpful?
A Yes. That's what I was about to do.
So I would suggest Figure 2-1 on page 6.
Q Okay.
A So this is the first --
Well, actually, you know, I think my --
the opinion I just mentioned is -- is, to some
degree, summarized in this figure, maybe not
completely. But the -- the top of the figure, I
identify eight different factors that have fed
into opioid prescriptions and utilization over
the years.
Q Okay.
A Yeah. And just -- I'll keep going if
you want.
Q Sure.
A Yeah. The first of those is FDA
approval. That's the initiating factor.
Obviously, there can't be any use of prescription
drugs without FDA approval, except for illicit
use, which we'll get to.
Medical need, actually, it looks like
in the figure that the word "need" is cut off
there, but it's in the narrative. But the
medical -- medical need just refers to the need

to prescribe pain relievers, pain relief medications to individuals suffering from either post-surgical pain, chronic pain, or breakthrough cancer pain, things like -- things like that.

Macroeconomic factors, these are identified in the literature as being associated with substance abuse generally and have also been identified as being associated with -- with opioid abuse.

Government advocacy refers to a variety of government agencies, including government payers, advocating for -- and better and more aggressive pain control. And, again, in my report I provide a lot of examples of this, that this was a concerted effort and sort of a -- you could describe it as a multi-agency concerted effort to -- to increase the rate at which individuals get proper or effective treatment for pain.

Provider advocacy is item number 5. Provider advocacy here I refer to in a similar capacity as government advocacy, except here I'm referring to mainly medical societies and, in some cases, also individual physicians, but it's mainly physicians acting as groups and promoting

clinical practice guidelines and things like that aimed at pain control. So these are the earlier generation of pain control guidelines which were, again, very sort of aggressive and suggesting that providers do a better job of managing pain.

Number 6 is performance incentives. These were incentives put in place by payers, public payers, private payers, a variety of other types of payers that were designed to provide financial reward for performance measures. And one common performance measure across a lot of different performance metrics is pain control. And that was something that was introduced in the time period I referred to in the sort of mid-'90s to early 2000s.

Seven is manufacturing marketing. This is also well-documented. Well, I should preface this by saying all of these are well-documented, and I go into that in detail in the subsequent pages. Manufacturing marketing is the one that I think most people have been hearing about, and there are, of course, studies showing that certain manufacturers engaged in marketing behavior that heavily promoted the use of opioids in the context of being able to address some of

the government advocacy, provider advocacy, and performance incentives.

And, then, finally, the last element, element number 8 is drug trafficking. There's a large number of -- a large and growing number of illicit opioids coming into the country by mail from China and across -- and by border crossing, mainly on the southern border. Mexico is a major producer of illicit heroin. China is a major producer of illicit fentanyl. Those are coming into this country in spite of the efforts of the Drug Enforcement Agency or Administration to limit that and in spite of the efforts of border patrol and in spite of the efforts of state police. It has been very difficult to stop the influx of opioids via drug trafficking.

Q Okay. I'll ask you a question about a couple of those. The manufacturer's marketing, in that box, do you include manufacturers' efforts to impact government advocacy and provider advocacy, in addition to direct marketing?

A Well, yes. I mean, that's -- that's a good point. I think that in some cases those are intermingled, and there's some evidence of the

intermingling of those things. I break them out as a separate -- I break out separately in this diagram and in my discussion because I do believe that there was separate and independent government advocacy that was taking place independent from manufacturing influence.

Likewise, I believe there was separate and independent provider advocacy that was also taking place independent from manufacturer influence.

Q With respect to all eight of these items, are you -- is it your testimony that they all are causes of opioid use disorder and the opioid epidemic?

A Yeah. I would say that they're primary -- I would just further distinguish that as primary causes. There are other elements involved. These are the primary causes, in my opinion, of the -- I would say more the rise in opioid utilization, whether it's prescription opioids or illicit opioids. Obviously, drug trafficking is driving illicit opioids, and provider advocacy is driving more prescription opioids. So there's some differences in terms of what types of opioids we're talking about here.

But, generally speaking, I would -- I would say that that -- that these factors are driving opioid prescription volume and utilization and then -- of which opioid use disorder is part of that. But I -- I don't -- I don't -- I wouldn't say that any one of these is directly associated with opioid use disorder.

Q With respect to the trafficking, the increase of people with opioid use disorder in part explains the drug trafficking we have with respect to synthetic or illegal heroin in this country; correct?

A Well, I'm sorry. Can you just rephrase that? I'm not sure I follow.

Q There are certain --

So the nonmedical use of opioids has led to a population with opioid use disorders. Correct?

A Well, yeah. So, just to clarify, so that within nonmedical use of opioids, there is a opiate use disorder subset of that group, yeah.

Q And that subset of that group is responsible for at least some of the increase in drug trafficking in this country. Correct?

A Well, so is what you're asking is

whether the -- the individuals of opioid use disorder, the sort of demand for illicit opioids in that group is encouraging drug trafficking? Is that -- is that where you're going?

Q Yes.

A Well, yeah. This is the supply push versus demand pull hypothesis. I -- I don't know that that's -- I mean, I think there -- I think it's a little above. I think there might be some truth to that, but I think there's also -- you know, drug cartels I think are very smart in terms of also creating demand for their products. And you look over history, and they've done a very effective job of that.

So I think -- I don't think it's -- it's not solely due to the demand among individuals with opioid use disorder. It's also -- it's a bit more proactive, sort of supply push on the part of drug cartels and illicit drug makers generally.

Q And what's the basis for your opinion on that?

A Just materials I've read in the course of doing this -- this project. I don't remember specific materials, but certainly some of the --

maybe some of the things I cite regarding -- or some of the bigger reports from the Drug Enforcement Administration touched on -- on that issue. I can't think of specific citations off the top of my head.

Q And why is FDA approval one of these factors?

A Well, in a lot of the capacity of my nonlitigation work with pharmaceutical -- new novel pharmaceuticals and the eval- -- economic evaluation thereof, and, so, I've been able to work with pharmaceutical companies in -- in the stages leading up to FDA approval and then following FDA approval. And through that process, I've become very familiar with the FDA approval process, and I think anyone in my business would agree that the FDA approval process is -- is a rigorous and difficult process to get through. They don't typically rubber-stamp new drugs and -- and devices and things like that.

And it's -- it's also a process that pharmaceutical companies have to pay a lot of money to -- to manage. So clinical trials are very expensive. There's multiple phases of

clinical trials that are necessary.

So in my mind, first of all, there can be no utilization of a drug without FDA approval, so it's sort of a gatekeeper in that regard. But -- but it goes beyond that and -- and I think there's -- there's good literature on this, that FDA approval is a marker of -- of -- of more general approval.

So, for example, payers will pay for things that are -- that it received FDA approval because they've assumed -- and most of the time I think it's incorrectly -- that the FDA has done its due diligence in analyzing the clinical trial data very carefully and basing its approval decision based on those clinical trial data.

Q You'll agree with me that opioids are in a class of drugs that are subject to regulation apart from the FDA?

A Yeah. Currently, you -- there's a distinction that they are currently that -- in that group. I would agree, yes.

Q Well, they've been subject to -- to regulation for over a hundred years, controlled substances have, haven't they?

A And, generally, yes. But I wasn't sure

what kind of regulation you're referring to. I mean, they're more regulated now than they were in the past, I would say.

Q And because of the -- are you familiar with the Controlled Substances Act?

A Only very generally.

Q And do you have an understanding that under the Controlled Substances Act there are certain regulations that are imposed on those in the distribution -- manufacture and distribution chain for controlled substances, of which opioids are one of those drugs?

A Generally familiar with that, yes.

Q And, so, in addition to FDA approval, there are other steps that -- that are in between use by a patient, either nonmedical or medical, and -- and FDA approval; correct?

A Yes. Yeah, generally correct. Yes.

Q And would it be fair to say that those obligations, like FDA approval, are required before the drugs leave the shelves of a pharmacy?

A Yes, I think that's fair to say.

Q So, for example, let's take the pharmacies. You know, apart from drug trafficking, opioid -- prescription opioid

medicine doesn't get in the hands of an individual person without going through a pharmacy. Is that correct?

A Correct.

Q So the -- so we could put a box 9 that said "pharmacies"; correct?

A Well, I -- I further -- I make a further distinction on this in chapter 8 of my report where I -- I view pharmacies as more of a gatekeeping factor rather than a primary causal factor.

Q Okay. All right. Well, we'll -- we can -- we can get to that later.

Well, let's just, while we're on the topic, what's the distinction? Why is -- why is -- why are pharmacies gatekeepers and the FDA is not? What's the difference between a pharmacy and an FDA in the FDA approval?

A Well, it can't -- I think of it this way, or I think of it this way. A drug can't be dispensed to -- to an individual with a prescription from their doctor unless it is first FDA approved. So that that -- there is that -- that's one of the first hurdles a drug has to get over.

Q Right.
A You mentioned a Controlled Substance Act, but you think of -- you could think of that as a second hurdle. I was just sort of lumping that in with regulatory approval. So that's -- that's my distinction between those two, that they couldn't --
One is an enabling factor. One, the FDA is an enabling -- enables a prescription of an opioid to be written.
These other factors that I've identified here are also -- can also be thought of as enabling factors or causal factors. Whether a -- a pharmacy --
I don't -- I don't agree that a pharmacy could be thought of as an enabling or causative factor because they're filling a prescription that was written by a doctor. That prescription, to some extent, was influenced already -- or writing that prescription was influenced by all these other things before it got to the retail pharmacy. So there's that temporal element in here as well.
Q So is it your belief that a pharmacy with a prescription from a doctor has no ability

to stop that prescription from being filled?

MR. BOONE:

Object to the form.

A I'm not sure that I would say no ability. I'm -- I am, again, in chapter 8, admitting to a -- a gatekeeping role. So there is some ability. And I think, likewise, there's some ability on the part of -- of all of these entities -- well, except for things like macroeconomic factors that are more macro and sort of not necessarily controllable in any centralized way.

But -- but a lot of these entities have a responsibility or an ability to -- to control the flow of opioids. And -- and my distinction here is that these eight were -- are -- are the primary ones, and a secondary one would be retail pharmacies, and I also identify consumers as having a responsibility. Again, that's not -- it's part of my opinion, but it's also documented that there is a sort of consumer contract or an implied consumer contract versus an explicit consumer contract to, you know, not abuse prescription drugs. So there is that -- that element as well. So -- but, again, I view that

as gate- -- more gatekeeping factor as well.
Q So if a pharmacy has certain duties -- and we'll use your gatekeeping characterization -- a pharmacy not meeting those legal and regulatory duties to serve as a gatekeeper, they would be an additional cause, then, wouldn't they?
A I mean, to the extent that they were found to -- to have not performed the duties that they were expected to perform, I would view them as having some -- yeah, some role in -- in their gatekeeping capacity, yes.
Q All right. Let's continue with figure 2-1.
A Okay. So we discussed the top of the figure, which is my eight causal factors, again, which the subsequent narrative describes those in more detail; then, in sort of flow chart design here where we're coming down into the medical use of opioids versus the nonmedical use of opioids, some literature that suggests the split is about 95 percent medical use, 5 percent nonmedical use. We typically refer, sometimes refer to the nonmedical use as diversion, diversion away from medical use. And, then, within that 5 percent of

nonmedical use, I further distinguish between three different things. You can have a non-cost-incurring misuse, you can have non-cost-incurring opiate use disorder, and you can have cost-incurring opiate use disorder. The distinctions are for purposes of analysis.

Q Okay. Let's -- I want to back up and ask you. So tell me the basis for your 95 percent and 5 percent characterizations.

A I think there's one study that I cite, but there are other studies that also have been cited. Let me see if I can put my finger on those.

I cite a couple of different sources, the Bowles study and the Saha study, which appear in footnote 41.

Q The category of nonmedical use, to what extent are those users people who started out in the 95 percent?

A I -- I don't know off the top of my head what that percentage would be.

Q So it's true, though, that nonmedical use of opioids can lead to --

No. Sorry. Strike that.

It's true that medical use of opioids

can lead to nonmedical use of opioids.
A Yes. That is true.
Q And you're not offering an opinion on how many people start off in medical use category and end up in the nonmedical use.
A Correct. I'm not offering that opinion.
Q All right. Let's -- let's go to your -- let's go down to the three boxes. Let's talk about the two green boxes. Explain to me what non-cost-incurring OUD is.
A These would be individuals who might otherwise be classified as having opiate use disorder by the strict definitions of opioid use disorder but incur no additional costs. So, in other words, they're not incurring criminal justice system costs or -- or healthcare costs.
Q But those are the only -- are those the only cost items you're looking at for the purposes of your analysis?
A Yes. For the purposes of my analysis, that's where my focus is.
Q And, then, what are non-cost-incurring misuse? What's that category?
A Well, this would be looking at -- with

the understanding that among nonmedical use of opioids there is more sort of general misuse and abuse versus OUD. So this would just --

Here I use the term "misuse" to refer to non-OUD nonmedical use, if that makes sense. And --

Q Can you give me an example of that?

A Well, yeah. So it would be an individual who is -- is taking their -- so it's nonmedical use, so they're taking their opioids in ways not prescribed by their physician, or -- or they don't have a physician and they're taking opioids obtained not through the healthcare system, and they are -- so, therefore, they're misusing them. But, again, they're not incurring any costs, so they're not -- they're not showing up, I guess, for lack of better term, in state Medicaid costs or state criminal justice costs.

Q People in the cost-incurring OUD category start out in one of the other two boxes. Isn't that true?

A Yes. They could be. Yes. They could start there.

Q Well, they all start there; right? That is, if you take the first -- you take the

first pill, you're probably not cost-incurring.
A Right. So as you -- as you move -- the way I have the boxes aligned is as you move from -- from the right to the left across those three boxes, you're getting, you know, you sort of -- you're becoming a more -- I don't know what the right word is. You're becoming more cost incurring or more acute or a worst-case fight by health definitions.
Q And then we have the bottom boxes, excess attributable cost.
A Right. So the -- and this just kind of lays the groundwork for the scope of my report. So here I'm saying I'm looking -- we're looking at cost-incurring opioid use disorder, and from that, what are the excess attributable costs to the state Medicaid -- a state Medicaid program -- in this case, New Mexico -- or state and local criminal justice costs, which is a source of direction.
Q How did you pick those two cost items?
A I picked these because I thought they were the -- the largest components of a state's costs that would be in any way associated with opioid use disorder. So recognizing that there

might be some other ancillary costs, I -- I -- I chose not to focus on those.

And, in part, there was also, for practical reasons, too, that I felt like I could get the most information for these two categories, where some of the ancillary other costs I -- I did not have a lot of confidence I'd be able to find a lot of evidence on.

Q What percentage of people who are diagnosed with OUD are Medicaid beneficiaries?

A I don't know off the top of my head. I don't know what that number is.

Q It's -- and a number greater than zero, though; correct?

A Correct. Yes.

Q And, so, none of their costs, excess attributable costs, are taken into account by your analysis; correct?

A Correct.

Q The state and local criminal justice, that's essentially the law enforcement -- I'll call it the law and order box. It's the police and the court systems, expenses necessary to run the police and the court system that you have attributable to -- to opioid use disorder;

correct? It would not -- would not include the cost to society in general. For example, if an addict is -- steals my bike off my front porch, that cost would not be included.

A Sorry. I wasn't able to hear that.

Q Hold on a second. I've got somebody at the door again.

MR. BOONE:

Hey, Anthony, Tony, would now be a good time to take a short break?

MR. MAJESTRO:

Yeah. I think that would be good. Yeah.

VIDEOGRAPHER:

We're off the record at 11:37 a.m.

(OFF THE RECORD.)

VIDEOGRAPHER:

11:59 a.m., we're back on the record.

MR. MAJESTRO:

Q Dr. Schneider, I think the question -- I'll just start over with the question I was going -- I was going to ask.

The excess costs that you are testifying about with respect to criminal justice don't include costs to victims of crimes;

correct?

A That's correct, yes.

Q They also don't include quality of life issues to communities that have crime that is a result of opioid epidemic; correct?

A Correct.

Q They don't include the cost of communicable diseases that might be spread by opioid addicts; correct?

A Um, well, no. I -- I -- generally, no. I mean, I think some of the Medicaid analyses that -- that have been done and that I rely on could potentially include inadvertently some of those types of costs.

Q But, for example, someone who, as a result of injecting heroin, transmits hepatitis or HIV to a non-Medicaid user, those medical costs would not be captured -- the medical costs to the nonmedical user from that exposure would not be captured by your analysis; correct?

A I think what you meant to say was to the non-Medicaid enrollee.

Q Yes.

A So, yes. And, then, yes is my answer.

Q Okay. Okay. I think I'm through with

questions on this first category of opinions. What was -- what's the second one? Let's go down the list.

A Yeah. And the second one, again, I'm kind of -- I'm working right now off of -- I mean, my report generally flows in the same direction, but I'm working off of the discussion on page 38 --

Q Okay.

A -- of what I call chapter 8. And, so, in that regard, we -- we've already covered, I think, in the previous discussion, my first two opinions, which would be -- number one was the multifactorial causation of opioid volume and utilization, and number 2 was the medical use of the 95/5 percent distinction. We've discussed both of those.

Q Okay. Before we get to those, I think what I'd like to do is discuss the opinions that you have in your report regarding Dr. Miller and Dr. Dobson.

A Okay.

Q And I think the first, as we're going through your report, I have is maybe on page 17?

A Let me see.

Yes.

Well, hold on. Let me just confirm --

I'm not sure if Dobson comes up before then.

Q Let me just -- let me ask -- just ask you without tying it to particular pages of the report. What opinions do you intend to offer regarding Dr. Dobson's analysis?

A Well, okay. So they're contained in my report, but I can try to kind of give you a top line summary.

Q Yeah.

A I would say, number 1, I -- I think Dr. Dobson's methodology is flawed in -- in a number of ways. It -- I think his identification of OUD patients is not -- not -- or I think is flawed. I think his identification or control -- the control for comorbidities is -- that is matched to his control analysis is flawed. And I think his objective on the abatement window -- in other words, trying to get -- trying to return to 1995 levels of -- of opioid -- I think it was opioid mortality rates -- is also flawed as an objective -- as an abatement window objective.

Q Now, are you speaking about Dobson or

Miller?

A Oh. Oh, well I was -- maybe I was conflating the two. I was starting out talking about Dobson. I may have ended talking about Miller.

Q Yeah.

A Yeah. Sorry about that.

Q All right. So you first indicated that you think Dr. Dobson's identification of opioid use disorder numbers is flawed. How so?

A Um, well, I think, you know, again, as I identify in the report, I think there's a tendency in administrative data for the identification of cases to be based on -- on cases that are already incurring a fair number of costs.

So in identifying OUD cases in Medicaid data, I believe Dr. Dobson's also identifying high cost cases or costs [sic] that have significant costs, if not objectively high.

And, so, in doing, there's this sort of confounding bias there in terms of his -- in terms of that approach. Or, actually, that's -- that's technically, I think, a collider bias in the sense that you're -- you're -- you're more

likely to come up with an attributable cost, a nonattributable --

Sorry. My phone is ringing. I was putting it away.

You're more likely to come up with an attributable cost in this scenario because you're identifying cases that already have with them -- associated with them a very high level of comorbidities.

And, so, there are other studies that help us just to sort of shed -- these individuals are much more likely to have a high level of comorbid conditions, HIV, hepatitis, things like that; in some cases, very costly comorbid conditions.

Q And how is that problematic? It would seem to me that -- that you have, you know --

I guess if persons in the population have comorbidities that are a result of their exposure --

The two you've identified are ones that have been causally linked to OUD. So I'm not sure how that's an issue.

A So -- so causally linked to OUD but not necessarily always causally linked to OUD. So I

think there's -- that that -- or it's -- it's omnidir- -- I'm sorry. Yes, omnidirectional in term of causation.

So some OUD patients are gonna be more likely to have HIV. Some HIV patients are gonna be more likely to have OUD.

But, then, I don't want to just focus on those two. I mean, there's -- there's -- there are studies that list ten or fifteen common comorbidities. I can't remember off the top of my head what some of the other ones are. But -- but they're -- they're highly, highly, highly more likely, you know, odds ratios of, you know, between five and ten, which is very, very high for odds ratios, indicating the likelihood of having those comorbidities.

So back to your original question, why is that a problem, it's a problem if you can't fully adjust or account for those comorbidities. In other words, if we were to say -- if we were to in some way be able to take them fully out of the equation, then we could isolate the OUD cost. But --

And anyone who does this kind of work, including myself, knows that that's very

difficult to do. It's very difficult to -- to disaggregate costs in patients that have layered on multiple comorbidities.

Q How -- how is it that you account for those in your analysis?

A Well, I don't. To be fair, I don't. Because I'm basing my analysis on -- on what I think is -- is one of the better attributable cost studies, and -- which I assume we'll get to in discussion. But when -- when -- when we get to that, I can tell you more about it.

But -- but that study is one that, you know, I think does a reasonable job of trying to mitigate these problems. But I -- I do not -- it's not my opinion that that study fully mitigated those problems or otherwise does a necessarily better job of [sic] anyone else of mitigating those problems.

Those medication control issues are common to any kind of -- anyone attempting to do this kind of work would face those problems.

I think if one had a, you know, an NIH grant spanning a couple of years, one could probably do a very good job of figuring out how to isolate those costs.

But I think, apart from that, the studies --

Certainly, the way I approach my analysis is to rely on some published studies, and, in so doing, I am also -- some of those problems that I identified do come into play unavoidably.

Q Okay. Then I think that your -- the third item you identified was -- and I think that's Dr. Miller's bailiwick, and that is the return, reducing the OUD numbers to his -- to pre-epidemic levels.

A Right. And apologies for conflating those two. But I think generally the extrapolation methods used are -- are also a -- sort of a common problem in -- in these types of studies. Any time an extrapolation has to be done, there are different ways to do it, and -- and I had issues with the way that Miller approached it. I recognize that the Dobson and Miller were essentially trying to synch up on some -- some of the issues that they were looking at.

Q Yeah. And, so, what -- what is your criticism of how -- the way Dr. Miller did it?

A Yeah. I'm sorry. I just got a notification that my network, my -- my connection was unstable. Can everyone hear me okay?

Q Your froze up. Your -- your voice came through fine. Your screen froze for a second, but it's fine now.

A Okay. Good.

Q Phillip gives us a thumbs up.

A Yeah.

So the question was what -- what was my -- my opinion about Dr. Miller's extrapolation approach. Is that correct?

Q Yes.

A Okay. Yeah. Dr. Miller opined that the correct landing point, if you will, for -- that would drive the ex- -- the extrapolations would be the 1995 levels of opioid -- I think it was opioid death rates, mortality rate. And my -- my opinion is that -- is that when doing this kind of abatement, one should look at what would be a -- what we -- the goal should be to return to a level that would be expected and, more generally -- I mean, more specifically, actuarially expected.

So, in other words, if we were trying

to mitigate -- let's say we were talking -- we were here today talking about obesity, which is another very, very costly condition, if we were trying -- if we were talking about abatement cost related to obesity, a question -- a reasonable question would be do we return to a situation where nobody's obese, which was, you know, pretty much in the 1950s, or do we return to some level of actuarially expected obesity, which would be some level of obesity we'd normally find in the population?

And, so, my -- my opinion -- this may not be the best example, but my approach to this would be to let -- would be to have an abatement window that corresponds to returning to levels that would be actuarially expected. And, so, I approach that --

I don't know if you want me to launch into my approach of that, but that's --

Q Yeah. Seems like it's as good a time as any to do that. Go ahead.

A Okay. So I -- I have a 10-year abatement window. And the way I came up with that was I noticed that the -- in terms of opioid prescriptions, so the volume of prescriptions,

peaked in 2012. So from -- from 2000 to 2012, it went from about --

I'm just gonna round off some numbers because I don't remember the specific numbers.

But let's say it went -- I think it went from 60 per 100 in 19- -- in 2000 to about 80 per 100 in 2012. And that fell from 2012 to 2017. So in a five-year period --

So, and again, in 12 years it went from 60 to 80. And it took five years, so less than half that time, to go from 80 to 60, back to 60. So it was around 59, I think, in 2017.

So opioid prescription volume went, again, from -- so I think the graph, it's 60, up to 80, back down sharply to -- back down to 60 in five years.

So in 2017, we were already at 2000 levels of opioid sales. So how far back do we go from there?

I had a little bit of a data constraint in that it was difficult to find data in the form that I wanted it in, which was prescriptions per 100 going back further than that. So what I did was -- was assume that in an additional five years, so from 2012 to 2017 -- again, we're back

to 2000 levels. In another five years, which I think was a very conservative assumption, we would return to levels around 1998, let's say, which would be -- you know, '97, '98, even '96, which would -- which would be what I would call actuarially expected opioid utilization, which would reflect medical need.

So, again, I'm -- I'm -- my opinion's based on the assumption that -- that -- and this is, I think, backed up by the medical literature -- that there still remains to this day a medical need rationale for opioids.

And -- and, so, my -- my opinion is that within ten years we would return opioid utilization or, again, opioid prescription, buying of prescriptions, to that level representing medical need.

Q That analysis doesn't take into account the number of opioid users who transitioned to heroin or fentanyl, does it?

A That's correct. It doesn't.

Q Okay. So we were hijacked -- I hijacked you. You were getting ready to delve into your third opinion when I hijacked you to discuss Miller and Dobson. So let's go there

now.
A Okay. I'm just gonna return to section -- chapter 8.
Well, again, actually, in your hijacking me to talk about Miller and Dobson, we also then addressed what I think would be my third opinion, which is these types of studies have important limitations that should be taken into consideration. In other words, it -- it -- one could argue that the attributable cost of OUD is zero. That could be argued. That's actually not my opinion here. But the -- but one could argue that because the -- because of the limitations of these studies, yeah.
So, I mean, again, we just went through it with Dobson and a little bit with Miller on the extrapolation. So...
Q And it's not that the attributable costs are zero. That would be that the studies don't establish what those costs actually are. Correct?
A Exactly, yeah. Yes, that's correct. So the studies don't -- the studies, you know, have something to offer. I'm not saying they're completely useless. But -- but they're limited.

One must approach these studies with precaution.
Q Okay. So, then, what page are we on now?
A Well, I'm sort of working off of page 38, although, you know, I think that this -- this isn't a list of the totality of my opinions because -- it wasn't really intended to be that way, but it's a -- just a -- useful for me to keep track of what I've covered.
And along those lines, item number 4 on that list, which would be 8.1.4, page 38, we also just discussed. So we've sort of covered that one as well.
Q Before we get there, can you -- I have some questions about table 6-2 on page 32.
A Hold on.
Okay. I'm there.
Q Okay. Could you give me a top-level description of what table 6-2 is?
A Sure. So the -- the heading, the row heading, baseline data, refers to data that comes from the Society of Actuaries report, which I know we haven't talked about much yet, but it's -- it's the report that I selected to serve as the reference point for my apportionment

calculations. And, so, the first, looks like, five rows there come from -- from that report. The -- the last row under baseline data refers to just trending those data up to 2021 so they're all in the same units. And I used the Consumer Price Index for that.

The bottom part of the table represents some adjustments I made to those costs prior to doing anything -- any sort of apportionment. Again, this is just U.S.

And again, the Society of Actuaries report goes from 2015 to -- to 2019, and the 2020 data I extrapolated using the average annual increase in each year from the Society of Actuaries report.

So the bottom part there shows a baseline state share of Medicaid cost adjustment and then the resulting number below that, and then a source from healthcare cost adjustment and then the resulting number below that.

So, again, this is taking cited actuary data, pretty much as presented, again, with the exception being the inflation adjustment, and then applying two adjustments, one for --

Since this is a U.S. table, I used a

baseline 50 percent Medicaid versus federal cost share. I get in later into how that changes for New Mexico. And then I applied the source from healthcare system data, which is from a --

This number's from one particular study. There are some other studies that corroborate this number.

Q So with respect -- (Zoom distortion.)

A Excuse me. I'm having trouble hearing you, counsel.

Q Yeah. Sorry.

So explain again the source from healthcare system.

A So this is --

I'm sorry. I cut you off.

Q No. You're good.

A Okay. The source from healthcare system data comes from I think a study that --

Let me just see which study I reference here specifically. Let me point you to the discussion.

Actually, I think it might come before that. Oh, yeah. This discussion starts in section 6.6 and continues into section 6.7. And with -- so -- so I direct your attention to table

6-1, which would be the top of page 30, and then the discussion below that in section 6.7.

So what -- what I report in table 6-1, which actually shows that number that appeared in -- in table 6-2 that you asked about, the top number in my table 6-1 in bold is that number, is that. So the 36.59 you see there, that's the 36.6 percent that shows up in the -- in table 6-2. And that's based on the study by Park and Wu. However, as I point out in section 6.7, I determined that there were some other studies that actually showed a lower percent of -- of opioid source from the healthcare system. So, conservatively, I chose the Park and Wu estimate but -- but was happy to see that there are some other studies that buttress that.

Q Okay. Let's go to --

Well, before we do that, on 6- -- on table 6-2 --

A Okay.

Q -- the state share reduction, that's just -- you're basically saying the state's paying 50 percent on average, not that the costs are 50 percent less; correct?

A Correct. That's correct.

Q And I take it, as a matter of law, you have no opinion as to whether the 50 percent number is the appropriate number versus the hundred percent number.

A Well, let me just -- let me just clarify. So the 50 percent --

So I think the answer to your question is yes. I'm not opining on anything legal here. But the -- I'm -- I'm arguing that the 50 percent is on average across --

Again, this table's focused on the U.S., not -- we're not into the New Mexico analysis yet.

But on this table, I'm saying, on average, typically, states only pay for or are only responsible for financing half of their Medicaid costs.

Q Okay.

All right. Let's go to table 7-1.

A Okay.

Q So the bottom- -- the bottom-line number, total excess Medicaid and OUD costs, those are annual for each of those years.

A Oh. Yeah. And, actually, this cursed table, which we've already edited, that should

probably say Medicaid and CJS costs.
Q I figured that's -- CJS --
A Excess. Yeah. Thank you. So I got distracted by that. Could you --
Q Yeah. So let's just clarify that. The total is the total criminal justice and Medicaid costs combined; correct?
A Correct. Yes.
Q From this -- from this table. You're just adding up the --
Like, for example, in 2015, you're adding up the 10.19 and the 6.90, what -- what's 17.09.
A Correct.
Q So that is the total for 2015. And then the numbers for each of the following years, those are annual numbers. They're not aggregate; correct?
A That's correct. Yes.
Q So let's go to figure 7.- -- 7-2A.
A Okay.
Q So the 2020 number is the same number that we -- it comes from the same table that we were just looking at; correct? The 8.45?
A Yeah. That's right. It comes from

table 7-1, the 2020 column of table 7-1.

Q And how -- explain to me how you're extrapolating out to 2030.

A So I'm taking the average annual decline in opioid prescriptions in New Mexico from 2015 to 2020. So that's the data that I have. So I'm averaging a decline of 11.56 percent. And I assumed that that average annual decline continues over this extrapolation period, the extrapolation period boundaries as I described in earlier testimony.

Q And, then, 7-2B does essentially the same analysis with respect to criminal justice system.

A Correct.

Q Okay. Now I think we're ready for table -- for table 8-1.

A I'm sorry. Which table?

Q 8-1.

A Okay. So -- yes. So 8-1, just to tie this in with the previous tables, it's the bottom row of 8-1. The 95.65 links up with the -- the 95.65 in figure 7-3.

Q Okay.

A Figure 7-3, of course, is based on the

extrap- -- the sum of the extrapolations from figure 7-2A and 7-2B.

Q Okay. So why don't you give me the top-line explanation of -- of how you get -- how you get to the -- the calculations in the right column, the far right column.

A Sure. So what I've done here is I've linked back to the earlier discussion in chapter 2, partly, and -- where I identify eight primary factors. I'm adding in two secondary factors here, retail pharmacies and patients, and I'm taking my total abatement cost estimate, abatement cost ceiling estimate --

Again, I'm not suggesting or opining that that is the right abatement cost, you know, the correct amount or the right amount. I'm just saying, you know, based on all the previous analysis, were the abatement cost ceiling to be this number, as I've calculated it, this is how I would allocate --

There's two -- two different options shown here in terms of allocating it across these different factors. So to some extent, that's what we're trying to do here, to the extent we're trying to figure out who's responsible for these

abatement costs. We talked about that earlier.

I -- I -- in the first two columns I'm saying, well, let's just assume it's proportional, and in the second two columns I'm saying let's -- let's give the primary factors a higher weight than the secondary factors.

So my final opinion on this would be the appropriate allocation mechanism would be the adjusted scenario where we give the primary factors a heavier weight than the secondary factors.

Q And what is your basis for saying that FDA approval has the same weight as drug trafficking, for example?

A Well, I mean, that's the -- the difficulty with this type of analysis. I'm not -- there's -- I'm not offering an opinion that there's a scientific way of deriving these levels of -- of responsibility. But as an economist, what one might do is -- is look at these different -- look at different weighting scenarios and keep them relatively straightforward and simple.

So I don't have enough data, for example, to -- to differentiate between the --

the enabling factor of FDA approval versus the enabling factor of drug trafficking in years since FDA approval. I don't have a mechanism related to -- to -- to make that allocation. And that's why --

Q For that matter, the allocation -- I take it, for that matter, the allocation to retail pharmacies and patients.

A I'm sorry. Ask that again?

Q I said and for that, the same -- I take it your testimony would be the same with respect to the allocations for retail pharmacies and patients.

A Correct.

Q There's not any literature you can cite to or economic analysis that you can cite to that says the secondary factor for retail pharmacies is 10 percent or 5 percent or 50 percent or 2 percent; correct?

A That's correct. But --

I mean, I'll just repeat that there is a -- there is a sort of an economic logic to this that has to do with all the preceding discussion in the report.

Q Okay. Explain to me the economic

logic.

A Well, again, if you go back to -- to -- to chapter 2 and some of the discussion there --

Because think about it this way. As you -- one could go through each one of these primary factors and ask the same question. Is it zero? Is it a hundred? I'm sorry. To be clear, is it zero percent or a hundred percent? You go through each one of these factors and land on something.

There are some economists who would weight things differently. So, for example, I think a manufacturer marketing, for example, would get weighted quite heavily by some analysts in this industry and some experts in this industry, or in this space, I should say, more generally. There are some who opine that government advocacy and provider advocacy were huge factors in this.

So -- so as you go down that list, you might -- you know, you can assign -- one can assign different weights to each one of those. You know, we can imagine surveying a bunch of experts and having them --

This is probably -- this is what I

would have liked to have done.

-- survey a bunch of experts, have them assign weights to each one of these elements and -- and use -- and do something like that.

So -- but I don't have privy to that data. I don't have the ability to do that. So I would -- I'm, instead, opining that it's not zero percent and it's probably not a hundred percent that you can assign to any one of these. It's some number in between.

So the -- saying, well, some number in between, so let's just -- and we don't know what that number is, let's do the apportion allocation. That's the column -- first set of columns.

And, then, the second set of columns, just simply saying, okay, well, I've already gone through the trouble of identifying primary factors versus secondary factors, primary factors versus gatekeeping factors, and, so, let's -- let's do the apportionment consistent with that discussion.

Q What -- other than your judgment, what can you rely on to differentiate the primary factors from the secondary factors?

A Well, again, I think I, as I try to describe in -- in chapter 2, that the secondary factors are distinguishable from primary -- I'm sorry. The primary factors are distinguishable from secondary factors because they had a causative or enabling element to them.

Q Okay. I'm just -- that same discussion again. Explain to me the patient secondary factor.

A Well, there's literature on sort of patient responsibility and the extent to which patients are responsible for using prescription drugs responsibly. And -- and, so, I -- I felt the need to include patients on this list rather than exclude them just because I was trying to capture all the different elements that -- that I think in some way factored into changes in opioid volume and utilization.

Q Are you saying that patients are at fault for becoming addicted?

A No, that's not what I'm saying. I'm saying that -- that if we're going to identify -- and my -- my sort of self-imposed remit in this section and also in the primary factors discussed in chapter 2 was to think about the scope of

responsibility in -- more generally in opioid -- in the volume of opioids and the use of opioids, so not specifically opioid use disorder.

So, in this case, I'm looking at things ---factors, as I said, discussed in chapter 2, these factors that are driving the -- the volume of opioid prescriptions.

And patients, there's literature on patients seeking opioids and the -- the -- the steps that -- that some patients take to seek opioids, and then there's also patients who are irresponsible or -- or are careless in their -- in their use of opioids. Again, we're creating a -- maybe falling into that misuse category. So I'm just, just for completeness, trying to make sure that the list is complete and that -- I think there's --

Again, there's -- there's medical opinion as to -- which I'm not offering, necessarily, but there are medical opinions as to what the patient responsibility is and the patient contract, which is another term that's commonly used regarding patient use of prescription drugs.

Q Okay. You would agree with me that

those situations -- scenarios are foreseeable consequences of prescribing a highly addictive drug like opioids?

A I think toward -- maybe not in the initial years following, let's say, the FDA approval of OxyContin. But I think --

Again, there's a point I make earlier in the report.

I think the medical community did become aware -- arguably, they were exposed to, at least, information regarding the risks around opioids. So physicians prescribing a bunch of opioids was often, you know, sort of blamed for, in part, the rise in opioid use. But, again --

Well, so, yes. I think I've answered your question.

Q So it's your -- it's your opinion that physicians were not aware of the addictive nature of opioids prior to sometime after OxyContin was launched in the '90s?

A No, I -- I wouldn't say that. I'm sorry if I implied that. No. I would say that there was -- there was probably some general awareness since long before that, you know, at least since 1945, and research that came out of

World War II, morphine and addiction and things like that.

So there was some general awareness of it. I think it -- you know, I think when you're talking about the physician community, it's -- it's all about diffusion. And the diffusion of knowledge around opioids, I think, took quite a while to work its way through the medical community. And as you can see on --

Actually, I can point you to -- it might help me make my point if we go to -- pardon me -- page 10, figure 2-2. And you can see -- see what's going on here. Just in general, the term --

There's -- there's always been publications on opioid abuse and opioids, medical publications. These are as indexed in PubMed using these two terms. But it was obviously a big uptick, you can see here, in 20- -- let's say 2010. And -- and -- and that, of course, the way the medical community typically -- the way information diffuses through the medical community, this would suggest that prior to that year that the -- the level of awareness may not have been where we would have wanted it,

necessarily, as a society, among physicians.

Q Okay. And your -- and the basis for 5 percent or 10 percent or zero or 90 percent in that category is the same -- same basic analysis that we discussed with respect to the other factors; correct?

MR. MAJESTRO:

We lost him.

Q Oh, there you go.

A I'm back. I lost everything briefly, and then it came back. Sorry about that.

Q Do you need me to repeat my question?

A I sure do. Yes. Thank you.

Q So the basis for ascribing a percentage to the patient secondary factor of 10 percent or 5 percent or zero percent or a hundred percent, I take it your analysis would be the same as for the other -- for the numbers for the other factors?

A Um, let me make sure I understand your question. So if I were to, let's say, conduct a separate study, you know, like we talked about surveying experts on what they thought were levels of responsibilities, is that what we're talking about?

Q Yes.
A Yeah. I -- I -- if I were to do a study like that, I would -- you know, I'd like to contact, like, a thousand different experts or 500 different experts, and I would also ask them --
Yeah. I would approach it the same way for each one of these factors and see what kind of responses I got.
Q Is it fair to say that table 8-1 is based on the two -- the two scenarios are assumptions? So if you assume proportional, that's the number you -- that's the number in the third column is what you get, and if you assume your adjusted scenario, the number in the last column is the -- is the number you would arrive at? Not that the -- that either of those scenarios is accurate, likely, whatever -- just whatever adjective. Those -- those two scenarios are just basically assumptions; correct?
A Correct.
Q And you're not going to testify that either one of those assumptions, to a reasonable degree of economic certainty, is accurate.
A Well, I -- you know, this is -- I

wouldn't agree with that. So I -- I put it in here for a reason, and -- and I put it in here because I thought these are two reasonable ways of approaching this problem. So I -- I think the --

My -- you know, again, my opinion is -- and I think I not just hint at this but I think I explicitly mention it in a few places -- that the -- just because there isn't a readily identifiable entity, which would be the case for several of these --

So FDA approval, I mean, I'm not sure -- I'm not even sure you can sue the FDA, so I'm not sure if that's a readily identifiable entity.

Medical need, obviously, there are some physicians who have been brought up on criminal charges already, but -- so for maybe -- but -- but that doesn't really fit in the medical need category so much. So -- so there's no real medic- -- there's no real identifiable entity there.

Macroeconomic factors, obviously not a readily identifiable entity.

So my -- my opinion is that just

because there's not a readily identifiable entity, there is a non-zero --

And I would argue that it's nonzero. But I think all -- I wouldn't have put any of these factors on here if I thought their impact, causal or enabling impact, was zero. I'm, instead, saying this is some non-zero number. So --

So in terms of it not being accurate, I'm not sure I would use those words. I would say that this is, based on the available evidence, this is -- this is one reasonable way to do it, and I would agree that -- or I would further opine that I think most economists would -- would look at this and agree that it's a reasonable way to do it in the absence of anything more specific.

Q So a lot of times when we're dealing with statistics and such, experts will calculate probabilities that a -- that a certain data point is within, you know, a -- you know, 95 percent probable it's within, you know, range X to Y. I take it you're familiar with that kind of analysis?

A Sure. Yeah.

Q You did not do that here; correct?
A Correct. Yeah. Kind of what you're talking about is like a bootstrapping approach where you can determine a confidence interval.
Q Yes.
A And, of course, there's the more technical kind of bootstrapping approach, which is what you would do if you actually had a big database, or if we had the kind of survey data that I was referring to hypothetically before. Yeah. So you could approach -- you could approach it that way. You could create a confidence interval.

I didn't have the ability to do that here, so there -- there's not a -- again, there's not a uniform source. Again, I can find -- there's evidence that says -- as I said before, there's evidence that says manufacturers --

Some experts who think that manufacturing marketing was -- they're 90 percent responsible. And there's some evidence or some -- some experts, I should say, that say that macroeconomic factors are, you know, say, 50 percent responsible for the problem.

So how do you take -- when you're --

when you -- when you have a bunch of estimates and they don't add up to a hundred percent, you have a couple of options. One is you can prorate them and force them to come up -- force them to proportionally sum to a hundred percent, or you can discount them. Because the problem is --

And I ended up doing -- discounting them. Because if you have a report that says the entire opioid situation was due to manufacturing marketing, I don't know that that expert took into account any other factors. So they're saying it was all due to that or all due to that and provider advocacy. There are some papers that reached those conclusions.

If that's their conclusion, I don't know that they've taken into account the other factors. So I don't know what their allocative process is. So that poses a problem for me. If I don't know what their allocative approach is, then I don't know what number to take from their study.

So if they say it's a hundred percent due to manufacturers, do I take a hundred -- if I take that, drop it into my table, then everything else goes to zero. And that doesn't, to me, seem

like an appropriate thing to do, because I don't think someone who says it's a hundred percent manufacturer's responsibility is taking into account other factors.

So what I'm trying to do here is actually trying to be fair and take into account what I think are all the factors rather than, say, just the ones in which there have been settlements or just the ones that have been the most vocal among the experts, et cetera.

Q Can you say, to a reasonable degree of certainty, that either the proportional scenario or the adjusted scenario is accurate; that those are the numbers?

A Well, yes. I think that's -- that's -- that's in keeping with my testimony here. So I'm --

I included both of these scenarios on this table rather than just the -- the one that gives the retail pharmacies the lower proportion because I think either one of these approaches is reasonable.

I think the proportional allocation just says we've got, you know, ten different entities. Let's split it evenly because we don't

know exactly how to nail that --

Q Okay. Doctor, I'm gonna stop you because I think you're answering a different question than the one I asked, so it probably means I have a bad question. So I'm gonna withdraw that question and ask it another way.

Can you say that it is reasonably certain that the proportional scenario is --

A Okay. Mr. --

Q I'm sorry?

A Excuse me. You're breaking up, and I don't know --

Q I think you're breaking up.

A One of us is breaking up. I don't know if the videographer knows who's --

I seem to still have a good Internet connection. I'm not sure what the problem is.

VIDEOGRAPHER:

Dr. Schneider, your Internet connection is going sort of in and out. On my end I can see your reception bars are white and then going yellow and then going red, and then you break up a little bit, but we still have clear audio, and then it goes back to white.

THE WITNESS:

Phillip, do you recommend I try switching to phone hot spots? It's my only other option.

VIDEOGRAPHER:

Do you have an Ethernet cable you can hard wire into the network? I presume you're on Wi-Fi.

THE WITNESS:

I'm on Wi-Fi, yeah.

No, I -- excuse me for a second. Let me --

No. There's no -- there's no Ethernet jack in here, so I don't think that's an option.

MR. MAJESTRO:

Q Sometimes -- it's my experience, sometimes -- and it works about half the time -- but if you just reboot your computer, it -- it either reconnects to a different frequency or does --

VIDEOGRAPHER:

Yeah.

MR. MAJESTRO:

You end up with a better connection.

MR. BOONE:

Tony, we're getting close to the

1 o'clock hour. I don't know if you're nearing completion of your questions. But if you've got more questions to ask and if we want John to reboot his computer, maybe we should break for lunch.

MR. MAJESTRO:

That's fine with me. I mean, I don't --

MR. BOONE:

If you're almost done -- if you're almost done, we can plow through. I mean, John's connection seems to be fine now. But those seem to be two options.

MR. MAJESTRO:

I'd like to finish the two questions I was asking, and then I -- I probably have another hour. Probably have less than an hour if I have a chance to go through my notes during lunch.

THE WITNESS:

Okay. Let's -- go ahead. And I'm sorry, Mr. Majestro. I'm going to ask you to repeat that again. I know this will be your third time through. But try it again, and I'll try to answer quickly before my connection goes.

MR. MAJESTRO:

Q This is the price I pay for not getting on an airplane.
A Right.
Q So my question is: Can you say to a reasonable degree of economic certainty that the percentages in your proportionate -- proportional scenario in table 8-1 are correct numbers, or the number, not a reasonable number?
MR. BOONE:
Object to the form.
A I mean, the way you're phrasing the question is I -- I would say that these are two reasonable allocation schemes. I don't know whether they are the correct allocation schemes. In other words, there -- there could be information out there that I'm not aware of, or, again, a hypothetical study that could address specifically this question, which hasn't been done. That -- that would shed some light on this.
And, so, I -- I would -- I would kind of summarize it by saying based on what is available now and what was available to me, it's my opinion that -- that either of these allocation scenarios are reasonable within --

within the field of economics.
Q Okay. And there also could be a hundred other reasonable allocations that a factfinder could come up with in this case, too; correct?
A Well, I'm not going to agree to a number, but there are other allocation scenarios that -- that -- that could be plausible, yes.
Q Or could be even reasonable, to use your term.
A Yes.
Q And back to my question, the are-these-the-numbers question, you'll agree with me that it's unlikely that the factors would be the same, each of the primary factors and each of the secondary factors would be the same number?
A Yes. I would agree with that.
Q Okay. I'm ready for lunch break.
A All right. Reconvening when?
Q I don't know.
MR. MAJESTRO:
Aaron, what do you want to do?
MR. BOONE:
It's 1 o'clock right now. How about we try for 1:45?

MR. MAJESTRO:

Works for me.

THE WITNESS:

Okay.

MR. MAJESTRO:

Q Does that work for you, Dr. Schneider?

A Yes, it does.

Q Okay. All right. We'll see you all in 45 minutes.

VIDEOGRAPHER:

The time is 12:58 a.m. We're off the record.

(OFF THE RECORD.)

VIDEOGRAPHER:

The time is 2:03 p.m. We're back on the record.

MR. MAJESTRO:

Q Afternoon, Doctor. I think we were -- I think we were finished with table 8-1. Let's go to table 8-2.

A Okay.

Q What is the basis for the percentage allocations in table 8-2?

A Well, I took the 5 percent from -- which would be the adjusted scenario, from table

8-1, which, again, as I said before, I believe is a more sizable, accurate representation of what an allocation scheme should be. And, so, I'm bringing that over into here and I'm applying a Kroger market share and an Albertsons market share as reported in those respective market share expert reports.

Q So this market share does not account for the number of potentially problematic prescriptions that the pharm- -- any of the pharmacies dispensed; correct?

A Well, just to clarify, so the pharmacies -- so the -- this -- and I guess some of the -- most, if not all, of the other cases allege that retail pharmacies are responsible to some degree for the -- for opioid use disorder via that -- their contribution to opioid volume. So that's the alleged, I guess, you know, complaint language.

So -- so because of that, I focus on, then, opioid volume, or number of prescriptions, whatever you want to call it. That's -- that's my focus. So you'll see --

Or, as we've discussed already, the theme from figure 2-1, which focuses on the

primal -- or primary causative factors and enabling factors for opioid prescription volume and then all the way through my analysis of abatement cost ceilings to this, it's all sort of consistently focused on opioid volume as opposed to other measures.

So I thought it -- to the extent that that's the -- or insofar as that's the reason why Kroger and Albertsons are named as defendants, then I will focus on their actual market share in terms of prescriptions sort of handled, I guess, in the case of the pharmacy.

Q So, again, then --

Let me ask the question -- a different question. Are you familiar with the claims based on the DEA's red flag analysis --

A As I --

Q -- in pharmacies?

A I'm sorry. I cut you off.

Q Yeah. Are you familiar with the red flag analysis as it applies to -- to retail pharmacies?

A In a very general sense, yes.

Q So if the theory of liability against the retail pharmacies is the failure to

adequately investigate red flag prescriptions, a market share analysis does not take into account how good or a bad job any of the pharmacies did in meeting that duty; correct?

A Well, yes, in the sense, also, that the -- the -- you know, the red flags themselves are not necessarily indicators of -- of misuse or OUD. So the red flags are merely process-oriented measures. They're, you know, from what I understand, imperfect measures of that process. And there's one -- I think there's one source I cite for that as an example.

Q So you believe volume is a better measure?

A Well, I mean, volume is kind of --

The way I look at it is volume is why we're here today. So retail -- I don't think retail pharmacies would be part of the discussion were it not for -- for volume. So I think I -- you know, I opine and, like I said before, I'm consistent all the way through my report, that volume is the right metric to look at.

And, so, if -- if we're looking at volume, then, yes, I think market share is the correct measure.

Q Paragraph 8.6.
A Yes.
Q Actually, I'm not gonna ask that question.
All right. Let's --
So you've issued the one corrected report. Are you aware of any other inaccuracies that exist in Exhibit 6 as you sit here today?
A I'm sorry. Exhibit --
Q Exhibit 6 is the April updated report.
A Yes.
No, I'm not aware of any other inaccuracies in that report.
Q So your opinion is complete and accurate, to the best of your knowledge?
A Correct.
Q Have you planned to do any additional work in preparation for trial of this case?
A Other than preparation itself, no, I am not planning on doing any additional work.
Q Are there any documents or testimony that you believe would be helpful in your opinions that you've requested that haven't been -- and haven't received?
A No.

Q So you testified you reviewed Dr. Miller and Dr. Dobson's reports. Do you know either of them personally or by reputation?
A No for both questions on Miller. Dobson I'm aware of -- I was aware of him as a health economist from the literature, but I do not know him personally.
Q How about by reputation?
A By reputation, only that he was a -- that he's a health economist. You know, he's a known health economist, known to me. No, I don't know anything about his reputation.
Q And, so, I take it that it would not be anything you would need to offer -- you would offer at trial regarding Dr. Dobson other than your analysis of the work he's done in this case?
A That's correct.
Q How about with the -- the other experts involved in the case that are potentially going to testify on the defendants' side? Other than the -- the two reports you -- from Dr. Glickman and Dr. LoSasso --
Well, first of all, do you know either of those two gentlemen?
A I don't know Glickman. I know LoSasso.

Q How do you know LoSasso?
A Just through the field, health economics. LoSasso had a fairly high-profile position for several years as the head of the American Society of Health Economists, and -- and I think before that he was pretty involved with the International Health Economics Association. So I knew him as a familiar face at those conferences.
Q Are you aware of any of the other experts who -- various other -- well, Kroger and Albertson [sic] and other defendants may have identified in this case?
A Experts for the defense?
Q Yes.
A Yes. Daniel Kessler, again, I would put him in the category of Dr. Dobson. I -- I -- Dr. Kessler, I don't know him personally, but I know of him from -- just from his publications and his work.
Q Do you have any opinions or testimony that you intend to offer about him?
A I'm sorry. Just to clarify, about him personally?
Q Yeah.

A Or professionally or --
Q Yes.
A -- reputation, that kind of thing?
Q Exactly.
A No.
Q Okay. I think that's all the questions I have. Lunch was helpful. I got to cross a lot of things off my list. So --
MR. BOONE:
Hey, Tony, give me just a few minutes to take a look at my notes --
MR. MAJESTRO:
Sure.
MR. BOONE:
-- and I'll see if I have any questions. Okay?
Let's go off record.
VIDEOGRAPHER:
Time is 2:14 p.m. We're off the record.

(OFF THE RECORD.)

VIDEOGRAPHER:
2:19 p.m. We're back on the record.

EXAMINATION

BY MR. BOONE:

Q Dr. Schneider, this is Aaron Boone. Thank you for your time and attention today.

I wanted to draw your attention to Section 8.5.1 of your report. Would you turn there, please?

A Yes, I'm there.

Q Okay. And this is in the section dealing with allocation specifically with respect to the market share of Kroger; correct?

A Correct. Yep.

Q All right. And, so, I'm gonna read that paragraph and ask you a question. It says, "For example, according to the expert report by Dr. Anthony LoSasso, Kroger has a 4 percent market share in New Mexico. Thus, based on the allocation scenarios shown in table 8-1, Kroger's OUD attributable 10-year abatement ceiling would be 191,305 before any further appropriate reductions."

Sir, if you could explain what you mean by "before any further appropriate deductions."

A Well, I mean, this would just be anything that -- that might be --

A further reduction could be, for example -- it could come in a lot of forms. So it could be that perhaps somebody determines that -- that the overall responsibility to retail pharmacies is less than 5 percent instead of 5 percent, for example. Other appropriate reductions could come from, for example -- other -- other parties could determine that there was some -- some limit on -- some additional limit on liability that comes from some other realm of the litigation, things like that.

Q Now, and there may be others, but a moment ago Mr. Majestro mentioned red flags and the red flag discussion that has circulated in this litigation. So if there was a proportion of the market share that plaintiffs identify as being, quote, unquote, a red flag prescription or a red flag market share, might that be another possible reduction that could be considered when determining these numbers?

A Yeah. Exactly. I mean, that's -- the second example I gave would fall into that category.

Q Okay. All right.

MR. BOONE:

Tony, that's all the questions I have for now.

MR. MAJESTRO:

All right. Anybody else or are we done? Going, going, gone.

MR. BOONE:

And, Tony, we will read.

VIDEOGRAPHER:

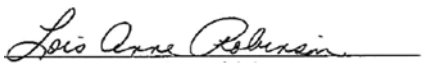
Okay. If there's nothing further, the time is now 2:22 p.m. This concludes today's testimony from Dr. John E. Schneider. We are now off the record.

(Deposition concluded at 2:22 p.m. EST.)

C E R T I F I C A T E

I do hereby certify that the above and foregoing transcript of proceedings in the matter aforementioned was taken down by me in machine shorthand, and the questions and answers thereto were reduced to writing under my personal supervision, and that the foregoing represents a true and correct transcript of the proceedings given by said witness upon said hearing.

I further certify that I am neither of counsel nor of kin to the parties to the action, nor am I in anywise interested in the result of said cause.



LOIS ANNE ROBINSON, RPR, RMR
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Please read your deposition over carefully and make any necessary corrections. You should state the reason in the appropriate space on the errata sheet for any corrections that are made.

After doing so, please sign the errata sheet and date it.

You are signing same subject to the changes you have noted on the errata sheet, which will be attached to your deposition.

It is imperative that you return the original errata sheet to the deposing attorney within thirty (30) days of receipt of the deposition transcript by you. If you fail to do so, the deposition transcript may be deemed to be accurate and may be used in court.

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E R R A T A

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ACKNOWLEDGMENT OF DEPONENT

I,_____, do hereby certify that I have read the foregoing pages, and that the same is a correct transcription of the answers given by me to the questions therein propounded, except for the corrections or changes in form or substance, if any, noted in the attached Errata Sheet.

_____

JOHN E. SCHNEIDER, Ph.D. DATE

Subscribed and sworn to before me this

_____ day of _____, 20____.

My commission expires:_____

_____

Notary Public